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Chemist&Druggist
The Newsweekly for Pharmacy

C&D

4 June 2005

Mezzanines add new dimension to contract entry

Lloydspharmacy pilots 'model contract' stores

'Near miss' study seeks shift from blame culture

Children's diet and nutrition in the spotlight

DIABETES

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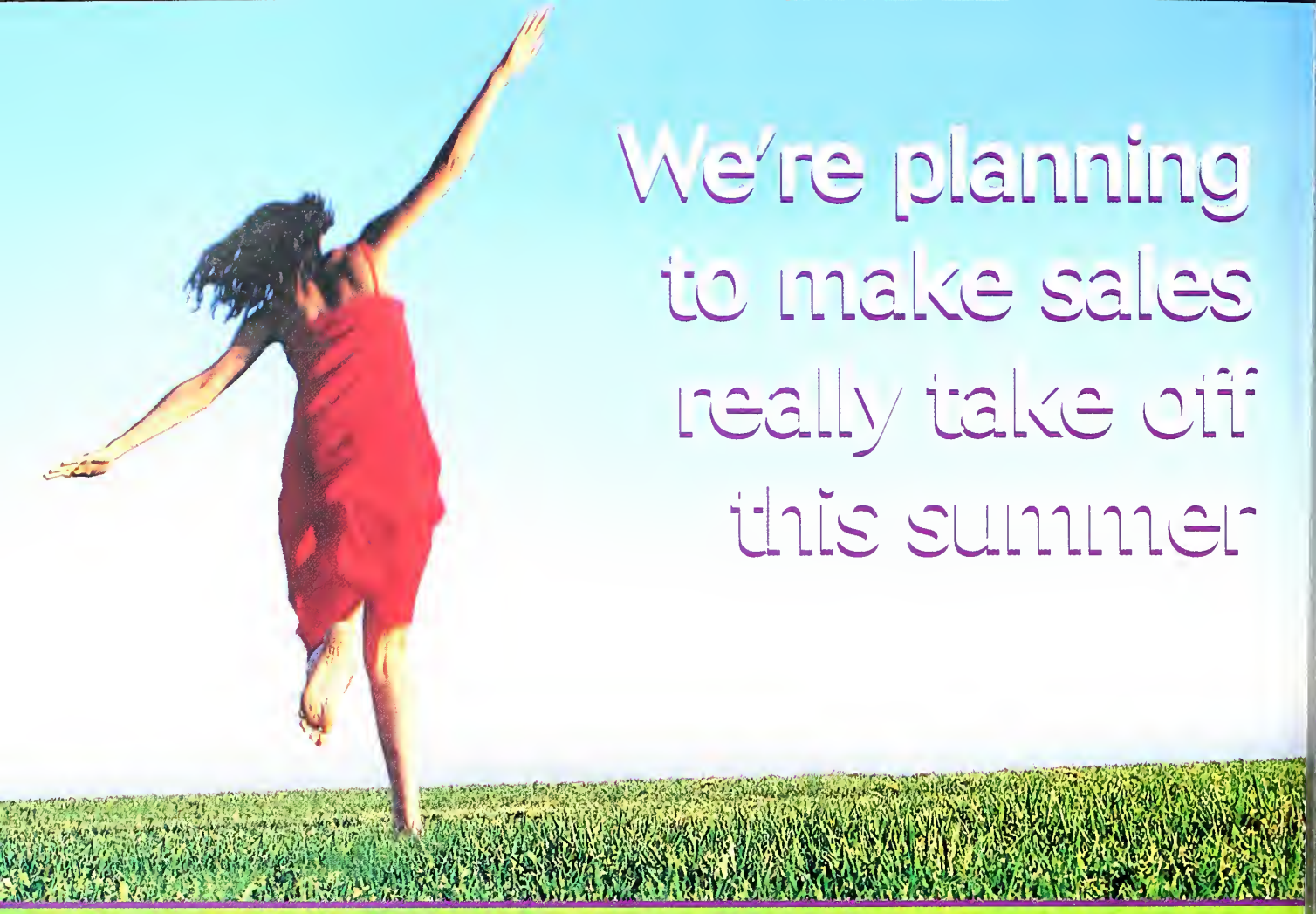

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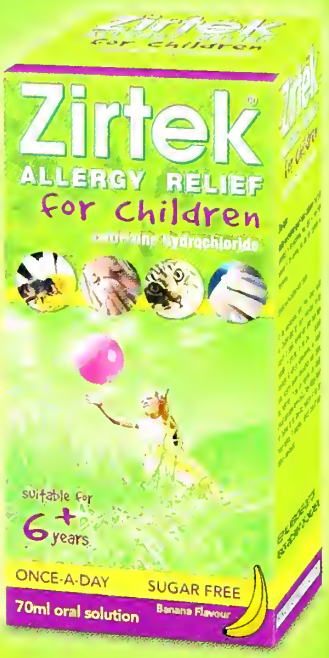

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This week

Regulars

Pharmacy update

Features

PSNC warns of contract loophole

by Adrienne de Mont

Pharmacy negotiating body PSNC has warned that uncontrolled addition of mezzanine levels in shops could threaten the viability of pharmacies.

PSNC believes that shopping developments under 15,000sq m should not be allowed to build internal floor space additions so as to become exempt from the control of entry regulations. Pharmacies in local communities could lose business to new pharmacies opening in such developments, says PSNC in response to a consultation document from the Office of the Deputy Prime Minister.

Two options are proposed in *A consultation on planning control of mezzanine and other internal floor space additions*, but the document invites further options if they are supported by clear evidence of costs and benefits.

The first option would be to retain the existing definition of 'development,' leaving retailers free to install mezzanine floors without the need for planning consent, except where the maximum floor space already had limits imposed. Although authorities have powers to revoke permissions, these would involve compensation payments, so are unlikely to be used.

PSNC favours a second option based on a 200sq m threshold, equivalent to about two standard shop units, above which planning permission would be required. Uncontrolled mezzanine installation, particularly in out-of-town locations, potentially undermines Government aims to support town centres and local pharmacy services, says the committee.

Without the 200sq m threshold, the Government's policy on combating social exclusion could be affected, as pharmacies in areas of high deprivation may no longer be viable.

The consultation document explains that mezzanine floors can be a quick and easy way to make better use of buildings and in the right location can promote town centre viability. But they can have the opposite effect if the development is out of town.

Option one would enable retailers to continue improving their business efficiency and would not impose additional planning applications on local authorities.

Option two would enhance retail activity in town centres, contributing to their vitality and encouraging greater use of public transport, walking and cycling rather than private cars. The consultation period ended last week.

For more information:

www.psnc.org.uk

Consider LIFT local impact, warns NPA

Primary care organisations should consider the impact on their local community pharmacy network before funding 'super surgeries' that would also provide pharmacy services.

The community pharmacy network has an important public health role and if PCTs "put a pharmacy in a primary care centre where it is not necessarily needed" it may have a knock-on effect, creating a "deprived area", the NPA's NHS service development manager Neal Patel has warned.

His comments follow last month's National Audit Office report on the NHS LIFT scheme. Mr Patel was critical of the report's finding that pharmacy was identified as the 'most significant' source of third party income. "We want pharmacy to be on a level playing field with doctors and dentists," he said. It was unfair that all health professionals were not considered equal, especially as the new pharmacy contract was service driven, he said. **AF**

For more information:

www.nao.org.uk/pn/05-06/050628.htm

'Specialist' framework welcomed

Pharmacy organisations have welcomed the news that a framework is being developed to support pharmacists with special interests (PhwSI).

Commenting that they had already been working with NHS Primary Care Contracting, the Royal Pharmaceutical Society and National Pharmaceutical Association said they were pleased their discussions could now move onto a formal footing. The PhwSI framework will enable pharmacists to work with GPs, nurses and other health professionals to deliver improvements in primary care.

NPA pharmacy practice head Collette McCreedy said, "The PhwSI category together with the introduction of supplementary [illegible] independent prescribing and [illegible] contractual framework [illegible] particular expertise in [illegible] of patient care." **AF**

For more information:

[illegible].nhs.uk

Lloyds pushes pharmacy design frontier

Lloydspharmacy has unveiled the first of four concept pharmacies in Rubery, Bromsgrove, this week.

Three more pharmacies in Scunthorpe, Bristol and Coleshill, Birmingham, will be relaunched within a month. The four pharmacy formats will be tested for six months and will act as benchmarks for the rest of the chain and be models for design, layout and best practice, says Lloydspharmacy.

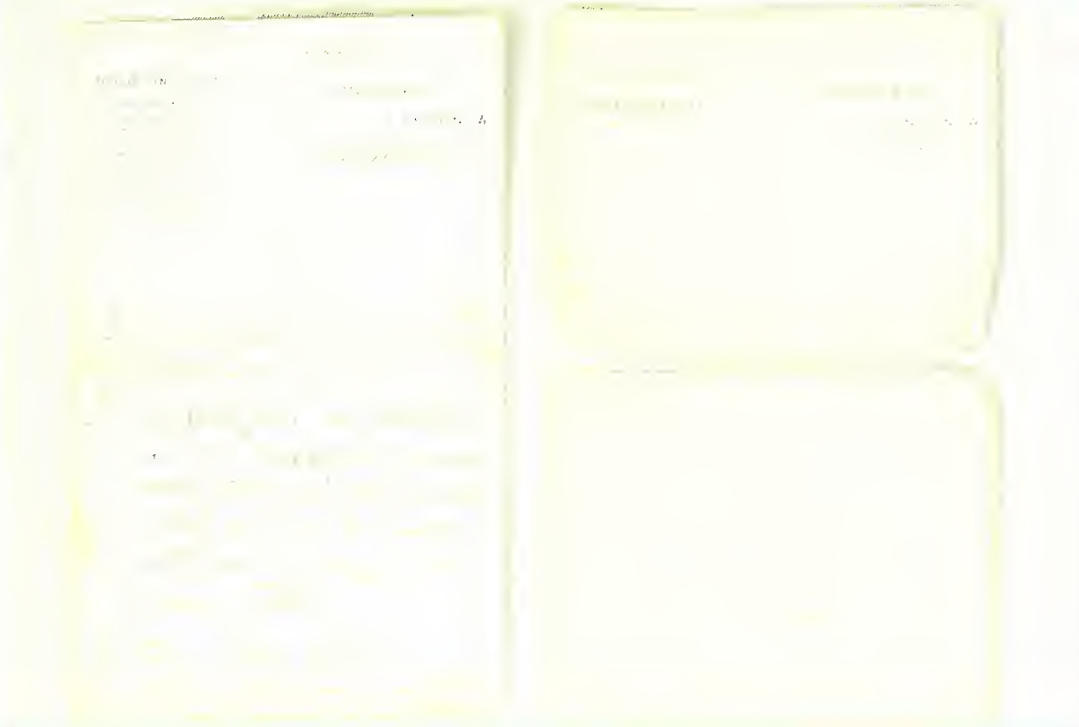
The four sites include a pharmacy in a healthcare centre, a neighbourhood community branch and two high street stores, with one in a small town centre and one on a neighbourhood high street. They will have features to support the new contract – such as dedicated care rooms – alongside future-oriented aspects including a free water cooler and Lloydspharmacy live in-store radio.

Once the six-month trial is complete and customer and staff feedback has been assessed, Lloydspharmacy plans to roll out a re-branding for the entire chain by the end of the year.

Andy Murdock, pharmacy director for Lloydspharmacy, said: "We are delighted to be pushing the frontiers of pharmacy design with these new concept pharmacies. Our customers will benefit from the ultimate pharmacy experience both in terms of retail design and by having direct access to the pharmacist either at the pharmacy counter or in the privacy of a designated care room … I believe these pharmacies are fine examples of how we are championing healthcare in the local community."

● Lloydspharmacy has begun training 30 of its pharmacists to act as facilitators for a series of contract-oriented workshops for its pharmacist workforce. From next week until early July, 48 workshops will run across England and Wales looking at each part of the contract, what pharmacists need to do now, the documentation required and how to implement new initiatives. Each workshop lasts a day and counts as paid study leave for pharmacists. **FS**

Lloydspharmacy: "Pushing the frontiers of pharmacy design"



'Blame culture' impedes pharmacy error reporting

by Adrienne de Mont

There is a low incidence of dispensing errors but attitudes to reporting them need to change if patient safety is to develop further in community pharmacy, a report has concluded.

Such progress is impeded by a pervading blame culture, which influences the way incidents are handled. Further research is needed to examine the detailed relationship between safety and performance in community pharmacies, say researchers from Manchester University.

A prospective study of dispensing errors in community pharmacies showed for every 10,000 items dispensed, 22 near misses and four dispensing errors were reported.

Among the 330 incidents, the most common types of error were product selection (60.3 per cent), followed by labelling (33 per cent) and bagging (6.6 per cent). Most incidents were caused by misreading the prescription (24.5 per cent), followed by similar drug names (16.8 per cent). Also associated with incidents were the pharmacy being busier than normal and phone interruptions.

A questionnaire survey of pharmacists and support staff showed that under-reporting, either within the pharmacy or to a national reporting scheme, was likely to be a problem. The researchers conclude that such schemes will require additional support and encouragement.

Focus group discussions revealed that a prevailing blame culture led to many errors being covered up. Barriers to reporting included lack of time, being blamed for the incident, complexity of the reporting system and uncertainty about the influence reporting would have on the situation. Anonymity emerged as an important feature in encouraging reporting.

Researchers have developed a reporting form and patient safety assessment framework suitable for community pharmacy.

The Community Pharmacy Practice Research Consortium, which commissioned the research, has published these findings in the final report of *Patient safety in community pharmacy: Understanding errors and managing risks*. The CPRC consists of the Royal Pharmaceutical Society, National Pharmaceutical Association, Company Chemists' Association and Scottish Pharmaceutical General Council.

The Society's secretary and registrar, Ann Lewis, said the low error rate was "a reflection of the care and attention that pharmacists pay to dispensing. However, we recognise that more work needs to be done to encourage the reporting of and learning from errors".

CCA's chief executive Colin Baldwin said members would find the research invaluable.

Sue Osborn, National Patient Safety Agency joint chief executive, said: "We need pharmacists to tell us about the issues they face every day."

In brief

Diabetes help

LifeScan UK is providing free information and advice on diabetes care to the public from June 17–18 as part of Diabetes Week.

In a series of roadshows at 40 Sainsbury's and Tesco stores across the UK, an independent healthcare professional will be on hand to provide help and support on all aspects of diabetes.

For more information:

lifescan@haygarth.co.uk

Tel: 020 8971 3300

Contract freephone

Pharmacy development group CAMRx has launched a freephone telephone support service for the new pharmacy contract. Members who require assistance should call 0800 526074.

Support team

GlaxoSmithKline has partnered with Ceuta Healthcare to provide a team dedicated to support pharmacies implementing +Plus medicines support services (MSS).

The Ceuta MSS team, consisting initially of 12 specialists, will work with +Plus account managers to help pharmacists adapt MSS to suit their needs and those of the local community.

So far, more than 1,000 pharmacies are planning or implementing more than 3,000 GSK supported MSS projects.

Update MCQ enclosed

This week's issue contains the questionnaire for the following Pharmacy Update modules carried in May:

- Headache part 1 (1336)
- Kidney diseases part 2 (1337)
- Selenium (1338).

Pharmacy Update is a distance learning programme accredited by the College of Pharmacy Practice. Previous modules can be accessed on the *C&D* website *www.dotpharmacy.com*. Further information is available from Mary Prebble on 01732 377269.

Genus Pharmaceuticals supports the MCQ and telephone marking service.

Newsdesk: 01732 377688

Work on paediatric meds to benefit pharma

by Asha Fowells

Drug companies which develop orphan medicinal products for use in children could benefit from 12 years' market exclusivity under proposals put forward by the Medicines and Healthcare products Regulatory Agency.

The plan would add two years to the 10 years' marketing monopoly manufacturers enjoy for orphan drugs for adults. Other measures detailed in the MHRA consultation that aims to increase access to safe, high quality and effective paediatric medicines, include:

- extending product patents by six months if the manufacturer has investigated use in children
- developing a Europe-wide database and network of paediatric clinical trials, and an inventory outlining children's therapeutic needs
- awarding 10 years' data protection for new paediatric studies
- introducing a waiver system for medicines unlikely to benefit children and a deferral system ensuring medicines are tested in children only when safe to do so
- introducing a requirement for pharmacos to include data on the use of a medicine in children when submitting a marketing authorisation application.

Comments submitted to the regulator will inform the MHRA's response to European Commission proposals on the regulation of medicines' use in children published last year. In the consultation paper, the MHRA says it supports the EC plans and considers a pan-European solution necessary to address the current situation.

Furthermore, the MHRA suggests two extra actions the EC should take. Making parts of a clinical trial database accessible to the public would increase transparency, says the organisation, which also calls for the establishment of a study programme to fund studies into the paediatric use of off-patent medicines.

Comments should be sent by August 17 to Caroline Brennan, MHRA, Room 16/162, Market Towers, 1 Nine Elms Lane, London SW8 5NQ or emailed to *caroline.brennan@mhra.gsi.gov.uk*.

For more information:

www.mhra.gsi.gov.uk

EUROPE

Europe fails to rule on GSK Greece case

The European Court of Justice has declined to give a view on the case between GlaxoSmithKline and the Greek Competition Commission (GCC).

The court rejected the case brought forward by the GCC alleging that GSK was conducting anti-competitive practice by capping the supply of its medicines to Greek wholesalers. GSK had restricted the supply of Imigran, Lamictal and Sercvent in an attempt to reduce the amount of parallel trade. The court declined to rule, saying the GCC "does not have certain characteristics of a court which are necessary in order for it to make a reference to the ECJ".

This means it is left to the Greek Competition Commission to decide whether GSK's actions have been anti-competitive: a decision that must take into account a ruling by the advocate-general that came down in support of GSK's actions.

However, this does not mean the case will not reach the ECJ again. If the GCC decides to support the advocate-general's decision, European wholesalers may take a case to the appeal court, which is a suitable body to refer cases to the ECJ. Similarly, GSK could appeal against a ruling against them.

GSK said it was "disappointed" the court had not supported the advocate-general's opinion.

Secretary-general for the British Association of European Pharmaceutical Distributors, Richard Freudenberg, said the decision was a "boost for continued competition in medicines supply". **FS**

Six months for ESPS fraud

A pharmacist who defrauded the NHS of £23,000 by inflating claims under the essential small pharmacy scheme (ESPS) has been sentenced to six months in prison at Winchester Crown Court.

In 2002, the NHS Counter Fraud and Security Management Service was alerted to Rajiv Sarna submitting NHS prescriptions through his Basingstoke branch, which had originated from his Reading and Ascot shops to prevent these two stores exceeding the ESPS threshold.

He repaid the full £23,000.

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References: 1 Hadgraft J, et al (2003) Skin Penetration of Topical Formulations of Ibuprofen 5%. An In Vitro comparative study. Skin Pharmacology and applied Skin Physiology Vol 16, No 3, pp 137-142. 2 Whitefield M, O'Kane CJA and Ahern (2002) Comparative efficacy of a proprietary topical ibuprofen gel and oral ibuprofen in acute soft tissue injuries: a randomized, double-blind study. Journal of Clinical Pharmacy and Therapeutics 27, 409-417. 3 Source: British Pharma[illegible] March 2005.

Healthcare should focus on the community

Scottish ministers and international cancer specialist David Kerr have produced a detailed set of recommendations for the future of the NHS in Scotland, which will change the way healthcare is delivered over the next 20 years.

Healthcare in Scotland should focus on providing care for an older population with long-term conditions and managing their care at home or in the community, said Professor Kerr in *Building a health service fit for the future Volume 2: A guide for the NHS*.

"The NHS in Scotland should be viewed as a service delivered predominantly in local communities rather than in hospitals. Ninety per cent of healthcare is currently delivered in primary care but the bulk of attention continues to be focused on hospitals," said Professor Kerr. "The NHS should work with other public services and with patients and carers to provide anticipatory care to prevent future ill health and reduce health inequality."

The report by the Kerr Group is the culmination of 14 months of investigation involving the public, patients and NHS staff. The recommendations will be debated after the summer recess and the Scottish Executive will make a formal response in the autumn. It does not replace *The right medicine*, which remains the main strategic document for healthcare in Scotland.

Lyndon Braddick, director for the RPSGB's Scottish department, said the report offered an opportunity for pharmacy in Scotland to play its part in delivering new models of care.

"We are particularly pleased to see the reference to the role of community pharmacies as walk-in centres with other healthcare professionals offering outreach services from pharmacy premises and the potential to offer direct access to self-care, chronic disease management and minor injury care in the communities where people both live and work."

The Scottish Pharmacy Federation was equally positive. Chairman James Semple said: "Professor Kerr's emphasis on the NHS as a service delivered predominantly in the local community rather than hospitals is welcomed and we are particularly pleased at the inclusion of pharmacy in this model." **JE**

For more information:

www.scotland.gov.uk/publications/recent

LEGAL

Defeat for cannabis 'pain-killer' claims

People who take cannabis for pain relief suffered a legal blow last week when a judge ruled against using medical claims as a defence.

Three of the country's top judges refused a test case challenge by five people who claimed at the appeal against their convictions that they used cannabis for pain relief. They had claimed they were entitled to a defence of "necessity" because the drug was needed for pain relief.

However, Lord Justice Mance said: "None of the defendants in any of the cases before us was in our view able to rely at trial on any facts which could at common law give him or her any defence of necessity." **UKL**

EDUCATION

Manager Maria qualified first

Maria Vera Rubio is Day Lewis's first accredited advanced services pharmacist, trained through *C&D*'s *Skills for the Future* course. She is the pharmacist manager at the Burgess Hill, West Sussex, branch. All of the company's 105 pharmacists and regular locums are registered on the course.

Smoking and obesity are key

The Northern Ireland chief medical officer's annual report highlights increasing obesity in adults and children, due to lack of exercise and unhealthy diets.

CMO Henrietta Campbell cites smoking as the largest preventable cause of ill health.

Windows to attract men

Pharmacy window displays which encourage men to seek health advice could win £800 in a competition organised by the Developing Patient Partnerships and the Men's Health Forum for Men's Health Week (June 13-19).

irmgavin@dpp.org.uk

Questiontime

This week's question:
When do you think management skills for pharmacists should be taught?

- Undergraduate course
- Pre-registration year
- Once registered
- No formal training needed

You have until noon on June 7 to vote at *www.dotpharmacy.com*. We will publish the results in *C&D* on June 11.

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Novartis Consumer Health, Wimblehurst Road, Horsham, Sussex RH12 5AB. Customer Careline 01403 218111 Fax 01403 323919 Email customer.care@[illegible].com

Don't sign to ETP suppliers yet, says PSNC

by Adrienne de Mont

Contractors should wait for Government guidance on the compliance status of pharmacy computer systems with the NHS's IT agenda before purchasing a new system, the pharmacy body PSNC has warned.

NHS Connecting for Health, the agency behind electronic transfer of prescriptions, was expected to issue guidance in June, PSNC has said.

However, Geoff Mackay, customer technology controller at AAH Pharmaceuticals, the company that provided pharmacy computer systems for the first two pharmacies to trial electronic transfer of prescriptions, has been encouraged by their progress.

Over 6,000 prescriptions have been sent electronically since the first trial in Keighley, Yorkshire, went live in February. "This tells you that ETP is being well used and is now almost regarded as a vital tool," he said.

Initial teething problems at National Co-operative Pharmacy Group in Keighley, which included staff having to manually reconcile details of 10,000 patients on the practice system with each patient's demographic details on the NHS Spine, have now been fixed and Mr Mackay did not think it would be an issue in the future. He remained optimistic that the Department of Health would meet its target of 50 per cent of pharmacies in England participating in ETP by the end of the year. The 2,500 pharmacies using AAH's Link system should have the basics for ETP by then.

Changes to Birdsgrove House could cost £350K

It could cost up to £350,000 for the Royal Pharmaceutical Society's convalescence and treatment centre to meet current disability legislation.

Initial estimates suggest that capital costs of £350,000 would be needed to ensure Birdsgrove House complied with the requirements of the *Disability Discrimination Act*, the Society's finance and resources director Bernard Kelly said at last week's RPSGB annual general meeting. The findings of a feasibility study will be ready by the end of June and will give a clearer picture of the costs, he explained.

Birdsgrove House and the services it provides have been subject to inspection by the National Care Standards Commission (NCSC) since 2003 and more recently from the Healthcare Commission. The NCSC advised in 2004 that unless Birdsgrove House's dual use as a treatment centre and rest and recuperation facility ceased immediately, an enforcement order would be served. The RPSGB had not informed members of the situation earlier because Council had made no decision on Birdsgrove House, Mr Kelly told the AGM.

Bill Brooks sought news of Birdsgrove at AGM

RPSGB president Nicholas Wood told the AGM that it was "time to have a debate" about Birdsgrove House. Pharmacist Bill Brooks from South Cheshire raised the issue at the AGM. He called for the Society to give details of how much the work would cost and asked when members would be consulted on Birdsgrove House's future.

In last week's report of the Society's AGM (*C&D, May 28, p4*), pharmacist John Gentle was quoted as saying the Society's PR had been "lamentable" and failed to adequately highlight the positive aspects of the Society's work. *C&D* wishes to clarify that the "lamentable" remark was directed at the handling of the Charter debate. Mr Gentle praised several aspects of the Society's work including sponsorship of a PhD student and its support for the All-Party Pharmacy Group. **GP**

SURVEY

Patient record access should be allowed in fraud investigations

NHS counter fraud and security management specialists should have access to relevant documents to assist in investigations of fraud, but there are concerns about patient confidentiality, says a Department of Health consultation document, *Access to relevant documents, records and data to counter NHS fraud*.

The DoH sought the views of 47 NHS organisations, associations and individuals on possible legislation to allow fraud and security specialists access to files. While the majority agreed that only CFSMS accredited fraud specialists should have access to records, they also suggested that authority should be sought to require entry to premises or to require explanations from individuals.

The DoH said any patient clinical records obtained would only be in relation to the allegations being investigated and would be anonymous wherever possible. The main interests of the security specialists would be in non-clinical information.

The DoH recognised the need to justify access to such information and to reassure individuals and representative bodies about its use, and would consider publishing a code of practice for fraud specialists to be used when obtaining confidential personal information.

More than 80 per cent of respondents thought a clinical specialist could take part in some investigations to ensure that the care given to patients was not prejudiced. While some respondents felt that having seven days to provide relevant documents was reasonable, others thought the time limit should relate to the type, ease of access and quantity of documentation being sought. **JE**

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Help them enjoy weeks of freedom from recurrent heartburn

Zanprol® Tablets, taken as a short course (2-4 weeks), can offer weeks of remission from recurrent attacks,[1] giving the oesophagus time to heal. So recommend a simple, short course of Zanprol, because that's the kind of thinking that really makes sense.

Product Information. Presentation: Each Zanprol 10mg Tablet contains 10 mg of omeprazole. **Uses:** Relief of reflux-like symptoms (eg heartburn). **Dosage:** Adults over 18 years only – 20 mg once daily before a meal. May be reduced to 10 mg daily, returning to 20 mg if symptoms return. Use lowest effective dose. **Contraindications:** Hypersensitivity, pregnancy/lactation. **Precautions:** Refer to doctor if no relief within 2 weeks, continuous use for 4 or more weeks to control symptoms, aged over 45 with new or recently changed symptoms, unintentional weight loss, anaemia, gastrointestinal bleeding, difficult or painful swallowing, persistent vomiting or vomiting with blood, epigastric mass, previous gastric ulcer or surgery, jaundice, any other significant medical condition (including hepatic or renal impairment), or pre-endoscopy. **Interactions:** Diazepam, phenytoin, warfarin, ketaconazole, itraconazole, cilostazol, voriconazole, digoxin, tacrolimus, ^{13}C-urea breath test. **Side effects:** Skin rash, urticaria, pruritus, photosensitivity, bullous eruption, erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis, alopecia and increased sweating. Arthritic and myalgic symptoms, bronchospasm, diarrhoea, constipation, abdominal pain, nausea/vomiting, flatulence, dry mouth, stomatitis and candidiasis. Increases in liver enzyme levels, encephalopathy in patients with pre-existing severe liver disease, hepatitis with or without jaundice and hepatic failure. Interstitial nephritis resulting in acute renal failure, gynaecomastia, impotence, headache, paraesthesia. Taste disturbances, mental confusion, agitation, depression, aggression blurred vision, blood disorders, hyponatraemia, vertigo, anaphylactic shock and angioedema, dizziness, light-headedness, feeling faint, somnolence, insomnia, peripheral oedema, malaise and fever. **Legal Status:** P. **Retail Selling Price:** 14 Tablets £9.49. **Product Licence Number:** PL 14017/0069. **Licence Holder:** Dexcel-Pharma Ltd. 1 Cottesbrooke Park, Heartlands Business Park, Daventry, Northamptonshire, NN11 5YL. **Date of Preparation:** November 2003.

Reference:
1. Bardhan KD, Muller-Lissner S, Bigard MA *et al*. Br Med J 1999; **318**: 502-507.

Important. If no relief is obtained after 2 weeks, or if continuous treatment for more than 4 weeks is required to control symptoms, refer to the GP

PAGB PERSPECTIVE

From little acorns...

... mighty oaks can grow. Sheila Kelly, executive director of the Propriety Association of Great Britain considers how an OTC switch becomes successful

Media coverage at the time of the statin switch verged on the hysterical. If we believed the hype then by now whole swathes of the middle-aged population of the UK would be statin users. That the uptake is more modest is being seen by some as a sign that OTCs for chronic use are not a goer.

Looking back at the significant switches of the past 20 years, I am far more positive. Pharmacists who now take it for granted that Nurofen is the leader in the analgesics market probably don't remember that the switch was considered radical back in 1983. It took a long time and a lot of advertising for ibuprofen to be seen as a competitor for aspirin and paracetamol.

Imodium struggled initially because it was more expensive than kaolin and morphine. Hydrocortisone was once considered so risky that pharmacists weren't allowed to sell it for eczema while vaginal thrush was a condition which definitely needed a doctor's diagnosis and couldn't be mentioned on TV.

When the H_2 antagonists switched, pharmacists were worried by media stories that they were going to mask stomach cancer. These concerns all disappeared as experience and confidence grew and the pharmacy market is the better for the addition of these drugs to a pharmacist's armamentarium.

We need to keep switches in perspective. The reality is that switching doesn't even begin to happen unless the safety profile is right and the CSM is sure that [illegible] supports it. Most [illegible] successful [illegible] take a while to [illegible]

[illegible] is cautious [illegible] know [illegible] is to [illegible]

illness for yourself.

After 14 years, sales of NRT products have reached around seven million packs a year while IBS sales are nudging towards one million packs. Compared with analgesic sales these are low but for the users they are important. Not every medicine has an unlimited pool of potential users. When the treatment is for prevention of illness then it will take longer for people to take an interest in a radical new approach to keeping healthy.

OTCs for chronic disease may not be so attractive to patients used to getting their medicines free on the NHS – pharmacist prescribing and patient group directions make more sense for this category.

But medicines for prevention of illness need to attract people who are currently healthy and not seeing a doctor.

The good news is that several thousand people are now using statins and pharmacists have identified people who need them – perhaps preventing them having a heart attack or stroke.

This is a key role for pharmacists and as health promotion is part of the new pharmacy contract it's an activity which has Government support. Success will come; it needs patience and confidence and the very good training support which is being provided by the industry for this switch and others.

MULTIPLES

Numark launches MUR toolkit

Numark has launched a medicines use review toolkit for members in England and Wales. It looks at the whole process of planning and delivering an MUR and also contains marketing material such as window posters and bag stuffers for use in store to raise awareness of the virtual chain's MUR service.

The toolkit covers:

- getting accredited
- selection and invitation of patients for a review
- explanation of service to local GPs
- preparing for a review
- conducting the review
- follow-up post-review.

Mimi Lau, professional services controller at Numark, said: "Following the reduction in generics reminbursement, pharmacists need to maximise their remuneration, so it makes sense to offer MURs. They really aren't difficult to conduct – it just needs thoughtful planning and preparation and consideration about when to offer them and how to fit them into the current workload."

Mimi Lau: "Pharmacists need to maximise their remuneration, so it makes sense to offer MURs."

The toolkit is available free of charge to Numark members through Numarknet, which is accessed through a secure user name and password. **JE**

For more information:
Professional Services Department at Numark
Tel: 01827 841200

RETAILING

Cambrian Alliance benefits from new contract

Pharmacy buying group Cambrian Alliance has seen a 25 per cent increase in membership in the last 12 weeks as UK independent pharmacists prepare for the new pharmacy contract.

Cambrian Alliance chairman Mark Griffiths attributes this growth to pharmacists' concerns about the financial implications of the new contract.

"It's too early to say exactly how the contract will affect profits but our new members tell us that the financial benefits we provide through collective purchasing are one of their primary reasons for joining Cambrian Alliance.

"The extended service we provide – including advice and lobbying – is also something they find extremely helpful in these rapidly changing times."

Cambrian Alliance, formed in 2000, now has 127 members.

RETAILING

Mainstream retail focus puts SSL in the black

SSL has turned around a £5 million pre-tax loss into a £21.7m pre-tax profit, on the back of repositioning its consumer brands in mainstream sales outlets.

In its preliminary year-end results, SSL International announced sales of £426.3m, up 4.4 per cent on the previous year-end. Key to this growth, said outgoing chairman Ian Martin, was the Durex brand, sales of which are up 4.4 per cent, thanks to the extension of the range into better, as well as safe, sex products and distribution through convenience stores.

Scholl footcare also performed well, raising sales 5.3 per cent thanks to the strong performance of the Party Feet range in high street fashion and shoe stores.

Sales of Scholl footwear, however, remained in decline as efforts to increase the range and widen distribution into mainstream retail continue.

Help active families with allergies enjoy the great outdoors

Recommend effective allergy relief that's taken just once a day and does not normally cause drowsiness. Piriteze Allergy Tablets and Piriteze Allergy Syrup – what could be better for active families who want to get out there and play?

Piriteze Allergy Tablets and Piriteze Allergy Syrup Product Information.
Presentations: Tablets containing 10 mg of cetirizine hydrochloride. Syrup containing 1 mg/ml cetirizine hydrochloride. **Uses:** Symptomatic treatment of perennial rhinitis, seasonal allergic rhinitis and chronic idiopathic urticaria. **Dosage and administration:** Tablets: *Adults (including the elderly) and children 12 years and over:* 10 mg daily. *Children under 12 years:* not recommended. Syrup: *Adults and children 6 years and over:* 10 ml once daily or 5 ml twice daily. *Children under 6 years:* not recommended. **Contraindications:** Hypersensitivity to constituents, breast feeding. Syrup: Severe renal impairment. **Precautions:** Use half dose in renal impairment. Tablets: Exceeding recommended dose may affect driving or operating machinery. Syrup: Caution in impaired hepatic or renal function. Maintain good dental hygiene. **Interactions:** Alcohol. Syrup: concomitant use of CNS depressants. **Side effects:** Drowsiness, headache, dizziness, agitation, dry mouth and gastrointestinal disorders. Tablets: Very rarely convulsions. Syrup: Somnolence. Very rarely allergic reactions. **Legal category:** Tablets: GSL (7 tablets) and P (30 tablets). Syrup: GSL. **Product licence number:** Tablets: PL 00079/0398 (7 tablets) and PL 00079/0399 (30 tablets). Syrup: PL 00289/0595. **Product licence holder:** Tablets: GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. Syrup: Approved Prescription Services Ltd, Brampton Road, Hampden Park, Eastbourne, BN22 9AG, England. Further information available on request from Medical and Consumer Affairs, GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Package quantity and RSP:** 7 tablets £3.99, 30 tablets £8.79; syrup 70 ml £4.99. **Date of last revision:** [illegible] 2005. **Piriteze** is a registered trade mark of the GlaxoSmithKline group of companies.

gsk GlaxoSmithKline Consumer Healthcare

Comment from the Editor

With so many expectations being made of pharmacy, there is a need to ensure that the people who work within the profession are of the highest calibre.

At last week's meeting of RPSGB branch representatives the British Pharmaceutical Students' Association won backing for the view that pharmacist undergraduate training should include management and 'influencing skills', with the BPSA president calling for an "urgent overhaul" of the pharmacy degree course. And this only five years after the degree was extended by 12 months to MPharm status.

Despite pharmacy becoming an increasingly employee profession, pharmacists will continue to be managers – not necessarily of businesses, but certainly of people and systems: as pharmacists extend their roles, other members of the pharmacy team will take on more of the core activities under the pharmacist's (possibly remote) supervision. For pharmacists to have some formal training in management skills, then, makes sense.

Pharmacy is not just about science; it requires a multitude of skills, some of them not so scientific. But the profession must guard against its scientific skills being lost or the profession evolving into two types of pharmacist – 'those who work with patients' and 'scientists'. The Schools of Pharmacy are already having this debate as the new 'vocational' schools compete for students.

With a sizeable complement of community pharmacists on the Society's Council, it will be interesting to see what they make of the BPSA's view. However, a more pressing need is to address concerns of a growing pressure on pre-registration places, so that undergraduates can embark on four years' training reassured that they will be given an opportunity to qualify.

"Pharmacy requires a multitude of skills, some of them not so scientific"

Their views

E-mail your views to chemdrug @ cmpinformation.com

Our question to pharmacists this week was:
Do you think ID cards are needed in the UK?

"Yes. I don't think they would necessarily make a difference in pharmacy if you work to SOPs but they would possibly make things easier in other places like banks"

Harvinder Dhillon, Idle, West Yorkshire

"I've no great objection as long as we don't have to pay for them. We live in a democratic country after all"

Anon, Cardenden, Fife

Our online poll at *www.dotpharmacy.com* said...

'Building a health service fit for the future' has pharmacy in its sights

Scotland's 'local' health priority

"It is important to be clear what we mean by local care. We see it as the delivery of safe, effective and sustainable services as close to the patient's home as possible. In some cases that might be in the home; in others it might be in the GP surgery or in the local pharmacy or in the local hospital.

"The overwhelming majority of people's health needs can and should be met locally. We start from a strong base in general practice. The patients' interaction with formal healthcare starts and ends in primary care for the vast majority (approximately 90 per cent) of people ... It has been estimated that in Scotland around 200 million 'health incidents' occur each year. Of these, around only one in eight result in a contact with the formal health services (other than pharmacy). The vast bulk of 'health incidents' are dealt with by some form of self-care – resolved entirely by the individual concerned, involving a visit to the chemist or with the help of family or friends.

"The new contract for community pharmacy ... will support self-care and provide direct access to pharmaceutical care services in local communities and this will be supported by specialist pharmaceutical care, when necessary, through managed clinical networks and community health partnerships.

"Given that pharmacies are situated where people live, work and shop in their local communities, they have the potential to develop wider access to healthcare and advice. Some will have other members of the healthcare team co-located, for example chiropodists, nurses and dieticians, allowing greater flexibility and choice in where services are delivered. With this co-location, direct access to services such as managing long-term conditions and minor injury care can be made available on the high street."

From: 'A National Framework for Service Change in the NHS in Scotland', (ISBN 0 7559 4669 3).

Northern Ireland NOTEBOOK

TOPICAL REFLECTIONS

New contract competition warms up

The competition for our new contract services is lining up even before they've been fully launched. NHS Direct's plans to proactively offer medication reviews and advice on long-term conditions (*C&D, May 28, p7*) would run in direct competition to pharmacy services.

We will have to work hard to add value to our services because we won't be able to compete on cost with a nurse working from a call centre. A face to face appointment is preferable to a phone call but we must offer more than a physical presence in a consultation room. Thorough access to patient records and effective communication with GPs will be essential because NHS Direct will certainly have these facilities. Our advice must be up to the minute and robust to compete with nurses reading from crib sheets of the latest information.

Some of the new services being discussed sound like a great idea, if the government will pay for them. I wonder why nobody had thought of calling patients to remind them about appointments and medication before. That must prove cost effective in the long term.

These plans are only at the discussion stage however, so we have plenty of time to establish our services as the premier option. And we mustn't forget that when NHS Direct was launched some people predicted that pharmacists' advice would become redundant. That didn't happen because we offer a premium service and as long as our services remain of the highest standard we should have nothing to worry about.

Gaviscon advances cleverly

I have to congratulate Reckitt Benckiser on its excellent marketing of Gaviscon.

The Gaviscon range has always been popular in my pharmacy but the Advance format was welcomed as a superior product that existed successfully side by side with the traditional version. Now nobody should choose traditional Gaviscon except for its cheaper price or simple familiarity, although some patients have told me they prefer its taste and texture.

But this is the clever bit, and the sort of move that probably only the brand leader could pull off: traditional Gaviscon is being discontinued – well at least the 500ml dispensing pack. Could it be that this is the start of a longer term plan towards discontinuing 'regular' Gaviscon, leaving only the superior (and more expensive) Gaviscon Advance? In time, for every 150ml bottle of Gaviscon I would sell at £3.29 I could sell a bottle of Gaviscon Advance at £4.19. My task of educating patients and GPs about the potential change seems worth the extra profit.

Less shrewd companies would have simply called their 'new and improved' formula "new and improved" and hoped to sell a few more at the same price. But as long as volumes don't drop too much, Reckitt and community pharmacists are quids in. Here's to patients sticking with this powerful brand.

Cartoon by Don Seed

Bank holiday bonus

Apart from the promised beautiful weather there are plenty of reasons why I'm glad to have a day off on bank holiday Monday.

Patients always go into a siege mentality before bank holidays and with the surgery closing on Saturdays the situation has become more acute.

I was swamped with prescriptions on Thursday and Friday as people prepared for being unable to contact their GP for three whole days. I feel I need an extra rest simply to recover from two days where I was close to meltdown.

Since the surgery has closed on Saturdays, and also partly due to 28-day prescribing, bank holidays have become increasingly about issuing emergency supplies of repeat medication. This is just boring and doesn't earn an income.

Now what would I rather do? Perspire over the dispensary bench, or sip a cold beer in the garden on the late spring bank holiday?

Not good enough, DHSSPS

The consultation paper *Making the best use of the pharmacy workforce* was sent to pharmacists by the Northern Ireland health department, DHSSPS. It came with an explanation that, since the consultation was UK wide, the Department felt justified in sending the 'English' document.

So the English version had a light card-cover bearing the DHSSPS logo stapled to it. Not good enough, DHSSPS!

This flies full in the face of policy that local administrations have responsibility to govern locally. That said, and apologies if my ranting sounds pedantic to some, but there is the more practical matter that pharmacists will find it hard to comment on this document as they cannot easily recognise the local context.

I have no idea what *Vision for pharmacy in the new NHS* is or what it said. Our strategy is *Making it better* or at least it was the last time I looked. I accept that the *Medicines Act 1968* does apply to Northern Ireland and it is change to this piece of legislation that is being considered here. But it seems incredible that DHSSPS has chosen to ignore the role of the Pharmaceutical Society of Northern Ireland in all of this.

The DHSSPS has chosen to ignore the PSNI in all of this

That said, the proposals make sense. It is high time we had greater flexibility in the pharmacy workforce. I fully support making better use of the excellent staff we have. If training and registration is required of such staff then we need to recognise this and the way to do this is to give them additional responsibility.

Written by a community pharmacist practising in Northern Ireland.

Compiled by [illegible]

Retail gloom continues

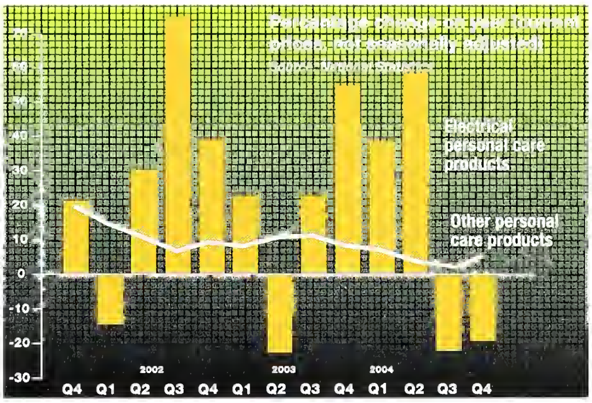
Retail sales

Chemists' sales fell sharply in April as retail business slowed overall to its weakest in two years, and the downturn seems entrenched. But high street spending is not in freefall and the evidence on consumer confidence is mixed

Retail pharmacists' sales fell sharply in April with 59 per cent of businesses reporting that annual volumes declined, according to a CBI survey. In March 39 per cent had suffered a year-on-year fall. Retail sales overall were below average for the time of year for more than a third of retailers polled. The British Retail Consortium says sales of **healthcare products** suffered from a late start to the hay fever season and **suncare products** were slower than in last April's warmer weather. In contrast premium **skincare and fragrances** did well. But official estimates suggest that total retail sales volumes grew 0.5 per cent in April and by 2.4 per cent annually. The value of sales by 'other stores', including chemists, rose 4.8 per cent between the two latest 12-month periods. Consumer confidence fell slightly in April, says researcher Martin Hamblin GfK. But business services firm Experian suggests confidence is on the rise, as fears of a house-price crash recede.

Consumer spending

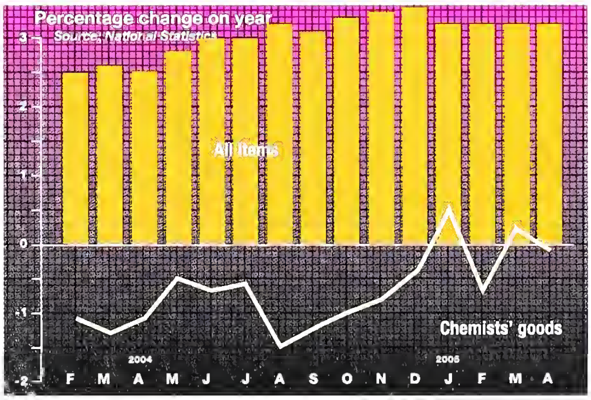
Demand for personal care products was mixed in the final three months of last year but outlays on health are forecast to rise during 2005 before slowing in 2006. Nonetheless the outlook for consumer spending remains lacklustre



Consumer spending on electrical **personal care appliances** fell in value by 19 per cent annually in the fourth quarter of 2004, officials estimate. Seasonally adjusted volumes fell 33 per cent. Spending on other **personal care products** rose in volume by 6 per cent annually, and by a similar percentage in value. UK output of **pharmaceutical products** fell by around 1 per cent in the first quarter of 2005 but declined by 6 per cent annually. **Perfume and toiletries** fell 6 per cent in the quarter and by 1 per cent over the year. Most UK pharmaceuticals and consumer chemicals makers expect domestic demand to stay flat in the short term, says the CBI. Consumer outlays on **health products and services** will rise 4 per cent in volume this year, and by a further 2 per cent in 2006, predicts Oxford Economic Forecasting. This suggests increases in sales values of 6 to 7 per cent. But the Bank of England says the outlook for consumer spending is "far from certain".

Retail prices

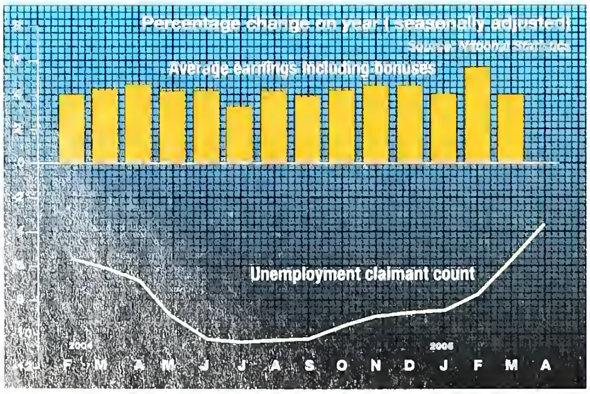
The average price of chemists' goods fell in the year to April. The drop in the UK factory gate price of pharmaceuticals accelerated, while the rise in UK manufacturers' prices increased, and the price of pharmaceutical imports firmed



The official **retail price index** for chemists' goods fell by 0.2 per cent in April, and was down 0.1 per cent at the annual rate, after rising by 0.2 per cent in the year to March. **Headline inflation** was unchanged for the third month in April at 3.2 per cent. The Government's preferred measure of **consumer price inflation** was also steady at 1.9 per cent. The British Retail Consortium says **shop prices** were 0.5 per cent higher in April than a year earlier, but **non-food prices** fell by 0.9 per cent. UK **manufacturers' prices** rose overall by 3.2 per cent in the year to April, from 2.8 per cent in March. Makers' prices of pharmaceutical preparations fell by 3.0 per cent annually, according to official estimates, after a drop of 2.4 per cent in March, while perfumes and toiletries fell 2.0 per cent. Lip and eye make-up fell 7.1 per cent annually but dental hygiene preparation prices rose by 0.3 per cent. Perfume and toilet water prices rose 0.5 per cent annually.

Earnings and unemployment

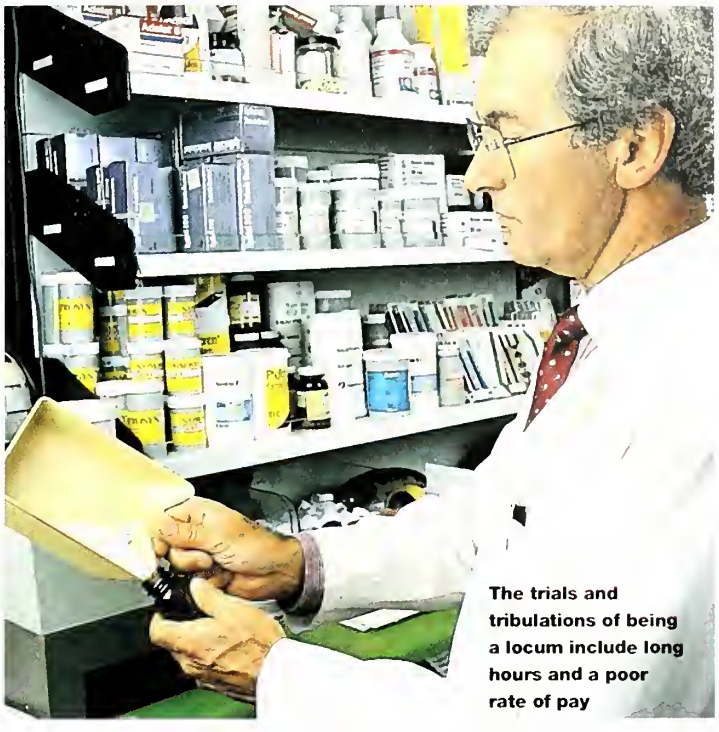
Average earnings growth eased marginally in the three months to March which suggests that inflationary pressures from the labour market are [illegible] benign. But [illegible] some [illegible] that skill [illegible] may [illegible] pick-up



In the first three months of this year, **average earnings**, including bonuses, were 4.6 per cent higher than a year earlier, compared with a yearly rise of 4.4 per cent in the three months to February. **Unemployment benefit** claimants rose by 8,100 in April, down 3.7 per cent on a year earlier. The **unemployment rate** averaged 4.7 per cent in the first quarter, while people in work in the first quarter rose by 183,000 on a year earlier. The Recruitment & Employment Confederation reports buoyant **demand for staff** in April, while the availability of suitably skilled people fell sharply. The result was an increase in pay inflation it says, although Incomes Data Services reports average **private sector settlements** in the three months to April only just above retail price rises, at 3.5 per cent. Payrolls in the service sector expanded in April at the fastest rate since last November, according to the Chartered Institute of Purchasing and Supply.

Sharing the contract responsibility

David Morgan lists some of the disadvantages of being a locum



The trials and tribulations of being a locum include long hours and a poor rate of pay

One of the advantages of being a locum pharmacist is that come closing time you just pack up and go home, with none of the paperwork, returns and reports to do. It also means that you can take a more relaxed view of the many changes which have affected community pharmacy from the beginning of the year, since many are not your direct concern.

However, this does not mean locums do not share the trials and tribulations of delivering the brave new world our political masters have mapped out for us, or the responsibilities of constant skills updating and continuing professional development.

Community pharmacy has rarely been in such a state of transition and upheaval and as much as pharmacy tries to be optimistic, it does have to be admitted that there is growing concern at the way matters are now progressing on just about every issue.

The new contract has entirely laudable aims and objectives but I see little happening at branch level that encourages me to believe that we are preparing enthusiastically for our extended role in delivering better healthcare and services to the public.

Doubtless there may be a lot of work going on elsewhere but nowhere has it yet filtered down to branch level, either from head or area offices or from the PCTs. Things are as they always have been, which means pretty chaotic, with minimal staffing levels of overworked and overstressed staff coping with increasing prescription numbers as doctors reduce the supply of repeat items to one or two months only. All at exactly the time that the Government reduces our income from straight dispensing.

Further, the rewards for implementing the various levels of the new contract are at such variance with the cost/benefit ratio that a growing number of pharmacists, especially private proprietors, increasingly believe that the whole exercise is just not worth the bother.

The swingeing reduction in the payment for key generics has landed on community pharmacy with the force of an Exocet missile and at a stroke has wiped out any financial benefit that many pharmacists expected to derive from implementing the new contract. PSNC must have been aghast at the scale of the reduction, which was unknown when the new contract was negotiated and which will leave the majority of pharmacies considerably worse off.

PCTs seem to be struggling to implement the introductory stage of the new contract as funding appears to be released piecemeal. My own PCT is struggling to implement MUR and has no funding yet for anything beyond. When I asked about pharmacist training I was informed that no funding for that was likely to be available in the near future or beyond, although they were aware of the demand, particularly by locum pharmacists.

The companies for whom I work have no plans to include me in their training schedules and the general attitude appears to be that it is up to me to provide my own training, at my own cost and in my own time. Yet since they are not improving staffing levels, particularly of pharmacists, locums will be expected to deliver at least some of the essential services.

Reading that many doctors are now earning in excess of £100,000 per annum, with no working weekend or unsocial hours, and many dentists nudging up towards that figure, my wife wants to know why I should work 10 hours a day for a figure that equates to barely a third of what my 'hardworking' local GP gets.

She is staggered that doctors and dentists always appear to negotiate more effectively and have more clout than our own representatives. More than one pharmacist has expressed the sentiment to me that our negotiators have yet again been taken to the cleaners by the DoH and in the words of one woman pharmacist: "We have been sold a pup and will have to pay the price."

Time will tell, but the omens are not good. Only the likes of the supermarkets appear to be rubbing their hands with glee. And we all know what that means!

Heart of the matter

OTC statins: The practicality of the pharmacy protocol

NOEL WICKS, MRPharmS
The Campus Pharmacy,
University of Stirling

This article is the fourth in a five-part series discussing the key issues surrounding OTC statins.

In recent years, pharmacy has seen a number of revolutionary POM to P switches. One of the most notable of which has been the switch of 10mg simvastatin. As with any innovation, pharmacists need to think about the way they practice in order to incorporate new learnings and processes. As such, this switch involved the provision of a protocol to enable pharmacists to easily establish a customer's risk of a heart attack and make recommendations accordingly. In my own pharmacy, I have found it extremely helpful to incorporate the protocol into my consultations with patients.

This process not only ensures I get the relevant information for a risk assessment but it also gives structure and direction to my engagement with customers.

In my experience, customers appreciate having a structured consultation and will feel more reassured if the pharmacist is confident in the process. While time is obviously an issue for all of us, as with most new procedures, it's just a matter of getting used to the process. In fact, the average consultation time is just over 7 minutes, with a quarter of consultations taking less than 6 minutes to complete.

A more personal consultation can also act as a useful platform for introducing lifestyle advice such as smoking cessation services. In my pharmacy, we have been able to set up a very effective and personalised service. This has been fundamental in developing customer relations and encouraging repeat custom. It seems this view has been shared by other pharmacists with 62% finding the extra time spent with customers beneficial to their business.

As pharmacy moves forward, and we see more POM to P switches, I am confident the consultation protocol will become pivotal to the provision of many OTC services.

Sponsored by McNeil Ltd

NEXT WEEK

Pharmacist Fin McCaul looks at taking the initiative

Branch reps

Motions on pre-registration and student issues were well supported at the RPSGB's branch representatives' meeting last week. **Asha Fowells** was there

Pharmacy education needs reviewing to ensure the workforce is both fit to practise and fit for purpose, delegates heard at the Royal Pharmaceutical Society's annual branch representatives meeting.

Calling for an "urgent overhaul" of the MPharm undergraduate course, British Pharmaceutical Students' Association president James Wood said it was important pharmacy students had the right skills for the future. Surely it would be better for students to learn management and influencing skills instead of complex chemical reactions, he asked, although he stressed that it was important to retain a good science content.

A review of the MPharm course was called for at the BPSA conference earlier this year, explained Mr Wood. Furthermore, if the Society agreed to look at the MPharm core syllabus, it would present an opportunity to assess the need for clinical placements, course funding and pre-registration places, he said. The motion was carried.

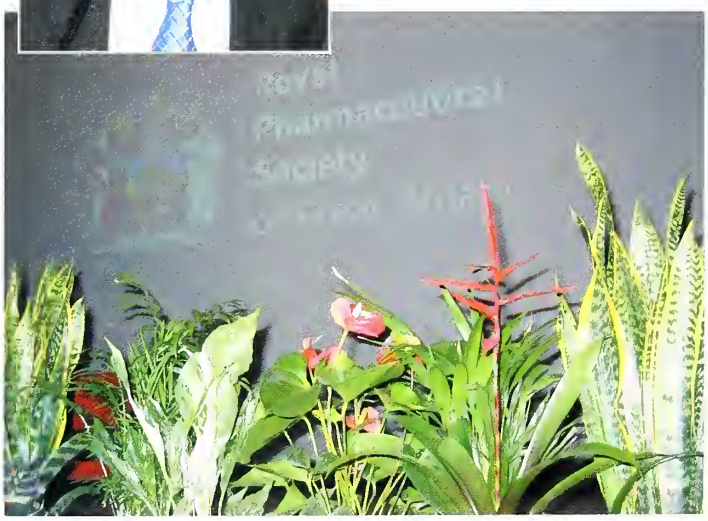
BPSA president James Wood: review the MPharm course

Francesca Ovenden, Northamptonshire branch, continued the theme by proposing an evaluation of pre-registration training. The registration examination appears to test graduates' academic ability, which has already been clarified by passing the undergraduate course, and not what happens in practice, she argued.

"The pre-reg year should be a time for professional development of the competences needed to become a good pharmacist," said Mrs Ovenden. She suggested setting up a structured course that included modular examinations to break up the pre-registration year and ensure all students covered were tested on all aspects. The motion was carried.

The RPSGB should endeavour to increase the number of placements available to pharmacy graduates, said Gavin Miller, West Metropolitan branch. Highlighting the fact that the number of graduates is expected to double by 2010 due to the new Schools of Pharmacy, he said the number of pre-registration placements would not support this increase in demand.

"The point of increasing student numbers is supposed to be to increase the number of



Overhaul training, say RPSGB branch reps

RPSGB branch representatives voting at the annual meeting at the Society's headquarters in London last Wednesday

pharmacists, but if pre-reg places don't go up, it won't happen," pointed out Mr Miller. Citing the case of a student who had successfully achieved the MPharm but had been unable to secure a training placement, he added: "This is not a problem of the future, it is a problem now. We need to ensure all pharmacy graduates have the opportunity to undertake pre-reg training."

Seconding the motion, the West Metropolitan branch's Patrick O'Sullivan warned that limiting the number of pre-registration placements available to pharmacy graduates might make the course less desirable. Pharmacy is seen as a vocational course, and if no training places were available it may lose its appeal, he said.

Peter Jones, Edinburgh branch, suggested that the Society and employers improve the training offered to pre-registration tutors to reduce the shortfall. Although the Society could not take any direct action to rectify the situation, Mr Miller said it could use "indirect mechanisms" such as introducing support groups for tutors and allowing trainees to work between several independent pharmacies. The motion was carried.

Just one of the 18 motions submitted to the meeting was lost. A proposal to include technicians in branch activities, put forward jointly by Clwyd and South Cheshire branches, stimulated much debate. However, meeting participants appeared swayed by Bruce Rhodes, Cheltenham and Gloucester branch, who said: "I feel strongly it's wrong. It's the thin end of a long wedge. Pharmacists and technicians have complementary but different roles."

Two more motions regarding the branch system were tabled. Alan Cranke, Teesside branch,

Continued on page 22

asked for the Society to provide sufficient funding so branches could provide a full programme without relying on commercial sponsorship. As pharmacists took on prescribing powers, they could not be seen to be influenced by the pharmaceutical industry, he said.

The Northumbrian branch called for branches to be given the discretion to award their secretaries higher honoraria. The current ceiling of £200 per year does not fairly remunerate branch secretaries for the time and effort they put in, explained Guy Jepson from the branch. Both motions were carried.

Proposing a motion from the Cheltenham and Gloucester branch, Bruce Rhodes called for the Society's Council to review its registration fee policy, particularly for pharmacists who practised part time. Both the profession and the public depended on this workforce and expecting them to pay the full retention fee of £256 was "financial nonsense", he said, adding that the cost of restoration to the Register meant these members might be lost to the profession altogether.

Seconding the motion, Brenda Ecclestone drew attention to two particular groups. Mothers of young children tended to work odd Saturdays to "keep their hand in", whereas pharmacists near to retirement age provided valuable emergency cover, she said.

Heather Elliston, South East Metropolitan branch, pointed out that the number of hours worked by part-time pharmacists varied. Introducing a part-time retention fee category could be divisive unless the meaning of "part-time" was defined, she said. Mr Rhodes said it was for Council to clarify the term, and the motion was passed.

The Northumbrian branch called for the RPSGB to provide members with the facility to pay retention fees by instalment. Proposing the motion, Guy Jepson said not all members could afford to make one large payment, citing students, new parents and people nearing retirement age as examples. Household bills could be paid by direct debit, so why couldn't the Society's byelaws change, he asked.

Mike Price, Gwent branch, warned that moving to a payment by instalments system could give the opportunity for fees to rise. Members would not necessarily notice because the payments would appear more affordable, he said. However, the motion was passed by a majority of 13 votes.

Other motions carried included:

- West Metropolitan branch – a new membership category, with an appropriate retention fee, for retired pharmacists should be created.
- Leicestershire and Rutland branches – material for campaigns supported by the RPSGB should be with members a reasonable time before the event.
- Lincoln and District branch – all tablets and capsules should be marked with a clear, identifiable, common code, to improve patient safety.
- Brighton and District branch – all community pharmacies should be obliged to operate a locum signing-in procedure to facilitate the resolution of any subsequent problems with that locum's work.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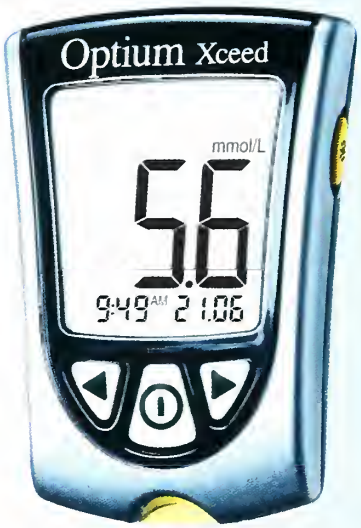

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CPD

This article can help in the following competencies: **C1f, G1c, G1a, C1a.** A list is available at *www.uptodate.org.uk/home/PlanRecord.shtml*

In a second article on the symptoms and diagnosis of headache, *Derek Balon* outlines which should be referred to a GP

Head for the doctor

THE COLLEGE OF PHARMACY PRACTICE

This course (module 1339), in association with multiple choice questions being published in *C&D* July 2, provides one hour's continuing education

Objectives

- To be aware of the danger signs of headache
- To know which signs are associated with brain disease
- To know which need instant referral
- To be aware of drugs that might cause headache
- To know the questions to ask patients

Some presentations of headache suggest that the patient requires referral to the doctor, perhaps without delay. While the previous article (*C&D, Pharmacy Update, May 7, p19-21*) covered headaches that might be treated in the pharmacy, this article covers those that generally need referral, although circumstances will dictate treatment.

A persistent headache lasting more than one day should be referred, especially if the symptoms get worse. By the age of 50 it is unlikely that a patient will never have had a headache, so anyone older should be referred if it is their first experience. This rule also applies to anyone in this age group who feels that their headache is significantly more severe than usual or if it is accompanied by pyrexia greater than 39°C and/or severe malaise.

A severe headache of sudden onset that worsens over time – especially a short time (a "thunderclap" headache) – requires urgent referral as it may be the result of an aneurysm. *Table 1* gives some examples of the danger signs pharmacists need to consider when assessing a headache.

There are many serious causes of headache that require referral and a few examples are discussed below. It must be emphasised that these are but a few of the many that require outside assessment.

Cluster headaches[2]

The name "cluster headache" is derived from the fact that they occur up to a dozen times or more in a 24-hour period and may continue for weeks, months or years. Diagnosis is based on the symptoms and the exclusion of any intracranial pathology (*see also Table 2*).

The pain is severe, unilateral, located peri-orbitally and/or temporally, and occurs up to eight times a day. It almost always occurs on the same side of the head and may be described as "being hit with a mallet". On the affected side, it is associated with at least one of the following: tears, red eye, stuffy nose, facial sweating, ptosis (drooping eyelid) and miosis (constricted pupil).

The pain lasts from 10 minutes to two hours. After one or two months, the condition remits but may recur a few months or even years later. The headache usually strikes without warning, though some patients report a sensation around the gums, teeth or eye just before an attack. Onset is often at night, and may disturb sleep.

The condition is more common in males than females and known triggers include alcohol, lack of sleep and barometric pressure change (atmospheric or flying).

Cranial space-occupying lesions

These should be suspected if the headache is recurrent or present on waking (although another cause of morning headache could be sleeping in a stuffy or smoke filled room). The pain of space-occupying lesions is intense, steady (not throbbing/pulsating) and episodic but seldom interferes with sleep. The location may reflect the site of the lesion. Other signs and symptoms include

Continued on page 26 ▶

A severe headache of sudden onset that worsens over time may be the result of an aneurysm and requires urgent referral

vomiting (without nausea), inequality of pupil size, drowsiness and sometimes convulsions (*see also Table 3*).

Headaches associated with brain diseases are characterised by the following: severe headache with no previous history; sudden and marked change in the character of a chronic headache; worsening of headache on exertion or straining; chronic, highly localised pain; lasting more than one day; headache that awakens patient from sleep; convulsions; memory disturbances or personality change; progressive worsening of symptoms.

Cerebral circulatory obstruction/ haemorrhage

Headaches caused by circulatory problems vary from mild to severe. Their onset may be abrupt, accompanied by neurological symptoms (nerve sensation, unconsciousness, paralysis of some area). Cerebral aneurysm may cause a pulsating feeling in the head and a rushing noise.

Table 1: Danger signs of a headache: consider referral[1]

- Severe, sudden onset
- Pyrexia over 39°C, especially if there is no known reason
- Mental confusion or decreased alertness
- Localised pain in the eye, ear or specific area of the head
- Trauma
- Recurrent, especially in children
- Headache that interferes with normal living
- Accompanied by convulsions
- Daily or frequent
- Persistent
- Aggravated by coughing, straining or stooping
- Causing disturbed sleep

Table 2: Diagnostic features of cluster headache

Symptom complex	Non-throbbing headache. May be accompanied by stuffy nose, lacrimation, red eye, facial sweating, ptosis (drooping eyelid), miosis (constricted pupil). No intracranial pathology
Region	Behind eye, spreads to side of face. Usually affects the same side of face
Universal factors	Provoked by alcohol and barometric changes
Time/Intensity	Intense, and lasting minutes to hours. Often occurs at night-time
Natural history	Recurs nightly, sometimes for a few weeks. Remits, but may return months later
Current medication	Not drug related

Table 3: Diagnostic features of headache caused by space-occupying lesion (brain)

Symptom complex	Steady pain. May be accompanied by vomiting (no nausea), mental problems, seizures, convulsions, weakness, drowsiness, or unequal pupil size
Region	Unilateral or generalised. May reflect site of lesions
Universal factors	No provoking factors, but sometimes positional
Time/Intensity	May occur any time but frequently on waking. May lead to fatal results within weeks to months. Intensity variable, but rarely awakens
Natural history	Worse in early hours
Current medication	Not significant

Meningitis

The headache of meningitis is usually intense and located occipitally. Pyrexia is present, and neck rigidity is noticeable even at an early stage. Other symptoms include photophobia, drowsiness and vomiting. A rash (which does not fade when subject to pressure) may be seen if the meningitis is due to meningococcal infection and is a serious sign of septicaemia (*see also Table 4*).

Drugs/noxious substances

Many drugs cause headaches (*Table 5*). However, it is the drug and the circumstances in which it is taken that dictate whether the pharmacist should recommend drug withdrawal or referral to a GP. For example, using a glyceryl trinitrate spray for angina may cause headache and reducing the dose (if the pharmacist recognises that the patient is overdosing) may eliminate the headache. On the other hand, carbon monoxide poisoning requires urgent referral.

Alcohol can produce headache in a sensitive patient. Excess alcohol intake, especially in those not used to it, may produce the typical "hangover".

Rebound headache

This results from overuse of analgesics to relieve the initial headache.

After taking headache-relieving tablets over long periods or in excessive doses patients find that, when the effects of the medication start to decrease, the headache is even worse and they take more.

Causative drugs include acetylsalicylic acid, paracetamol, caffeine, triptans and ergot alkoloids, and one or more agents may be involved.

The type of headache suffered varies. In one meta-analysis, 65 per cent of patients reported migraine, 27 per cent tension and 8 per cent other types (for example, cluster).[3] Women are much more susceptible than men (3.5:1). This condition may give rise to 10 or more headaches a month.

Rebound headaches occur daily, almost daily or very frequently. They affect patients with primary headache disorders who use immediate relief medications frequently, often in excessive quantities, and who have low pain thresholds. The pain varies in severity, type and location from time to time, and does not respond readily to analgesics.

Accompanying symptoms may include asthenia (lack of strength or energy), nausea, restlessness, anxiety, irritability, and memory loss. Tolerance to analgesics occurs over time.[4]

In addition, patients taking ergot derivatives or triptans may exhibit cold extremities, tachycardia, paraesthesia, diminished pulse, hypertension, light-headedness, muscle pain of the extremities, weakness of the legs and depression.

Withdrawal headache

This occurs when patients are taken off their analgesics abruptly. However, spontaneous improvement of headache occurs on discontinuing the medications.

Hypertension

Unfortunately, hypertension is a silent disease, and its incidence increases with age. Ageing itself is associated with other conditions, the symptoms of which demand a visit to the doctor, who then

Table 4: Diagnostic features of meningitis

Symptom complex	Steady, deep seated pain accompanied by stiff neck, pyrexia, severe malaise, photophobia, vomiting and possibly specific rash (does not fade on pressure)
Region	Occipital, generalised, back of head or bifrontal
Universal factors	Caused by bacterial or viral infection
Time/Intensity	Single episode, very intense
Natural history	Develops rapidly
Current medication	Not related

Table 5: Drugs and other substances that may cause headache

Ingestion
Alcohol, nicotine, caffeine, amphetamines, nitrates/nitrites, carbon monoxide, monosodium glutamate, ergotamine, analgesic abuse, oestrogens, fume inhalation – for example from dry-cleaning agents, tar or diesel

Withdrawal
Caffeine, ergotamine, narcotics

Table 6: Questions you should ask:

Open question	Prompt (closed question)
How long have your suffered from headache?	Just today, days, weeks, months, years
How often does the headache occur?	Daily, weekly, monthly, less frequently
How long does the headache last?	Minutes, hours or days
Have the headaches changed in frequency or pattern?	
What kind of a pain?	Continual, throbbing, dull, sharp
What part of head is affected?	All over, back, band-like, unilateral
Are there warning symptoms?	Flashing lights, stuffy nose, neck stiffness
Any other symptoms?	Diarrhoea, nausea, vomiting, sensitivity to light or sound, pain elsewhere
What relieves the headache?	Medications, rest, massage
Is the headache related to events?	Fatigue, exercise, sex, menstruation, food, alcohol, stress
Do you suffer from any other disease?	Hypertension, eye or dental problem
What drugs are you taking currently? Generally or for the headache?	Analgesics, caffeine, alcohol

diagnoses and treats the hypertension as well as the symptoms that caused the patient initially to seek medical advice.

Thus it is rare for a headache of hypertensive origin to be presented to pharmacists as the first symptom. However, pharmacists should bear this in mind when assessing headache in a patient who might be more likely to suffer from hypertension, such as the elderly, obese and those with diabetes.

Headache due to hypertension tends to be worse on waking and improves during the day. It is general (not in a band or located at a specific site) and often severe, sometimes waking the patient during the night. Dizziness may be present.

Heat stroke/ exhaustion

A patient who has been exposed to long periods of heat or strong sun may develop heat exhaustion. Symptoms include general headache, which can be severe, dizziness, nausea, loss of appetite, cramps and irritability. Tachycardia, hypotension and cold clammy skin are possible. Although water loss may have been considerable, thirst may not be apparent. Such patients require urgent referral.

Heat stroke (heat hyperpyrexia) is the result of direct over-exposure to sunlight, especially at the back of the head. Headache may precede collapse from increased cerebrospinal fluid pressure. Again, urgent referral is essential.

Extensive sunburn may cause systemic symptoms including headache, nausea and abdominal cramps.[5] The combination of these symptoms may be sufficient to make a diagnosis.

Trigeminal neuralgia

This causes severe, intermittent head pain, which may present as headache.[6] Stabbing, shooting, electric shock-like pain in the distribution of the maxillary and mandibular nerves can be spontaneous or triggered by stimuli such as touch, cold air, chewing, talking, facial movement, brushing the teeth, or emotional distress. Trigger zones are usually in the central face around the nose and lips and may be quite small (1-2mm).

Depression is common in affected patients. The condition is outside a pharmacist's remit and must be referred.

Glaucoma

This is located in the eye and may be presented as a headache. Other symptoms may include vision disturbance and halos surrounding light sources. Referral is required.

Questioning patients

See Table 1.

The first article in the series and references for part two are available on the C&D website. www.dotpharmacy.com/upmauu.html

Derek Balon is a proprietor pharmacist and visiting lecturer at King's College London.

Actionplan

1. After looking at both articles on headache symptoms (*part 1 in C&D Pharmacy Update, May 7, p19-21*), write the word "headache" in the centre of a page in your practice workbook. Draw lines radiating from it, pointing to the common types of headache. List beside each type the major differential diagnostic features that enable you to arrive at a working hypothesis (diagnosis).
2. Using this diagram identify which conditions you would refer, and the urgency of such referrals.
3. Draw a table listing the headaches (identified in the diagram) you would treat, and record your treatment/advice.
4. Do you have any patients who suffer from cluster headaches? What drugs are prescribed, both prophylactically and therapeutically? Do they work?
5. Record in your practice workbook each time you are asked for advice about a headache. Note any that require referral. In three months what percentage require referral?
6. Are there any patient groups that require more rigorous questioning regarding their headache? Do these constitute a special risk group or are they already in risk groups? Do you need to inform your medicines counter assistants of such patients?

Distance learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education are reminded of the need to test their knowledge in support of Genus Pharmaceuticals. *C&D* readers can self-test their progress by using the multiple-choice question (MCQ) paper to be inserted in the July 2 issue, which will cover this week's CPP-scored learning module together with those in the June 11 and 25 issues. These will cover:

● **Headache part 2 (1339)** ● **Basic bugs part 3 (1340)** ● **Minor ailments part 1 – diarrhoea (1341).** A telephone marking service offers independent verification of results – details on the monthly MCQ papers. People wanting to register for Pharmacy Update can contact Mary Prebble on 01732 377209.

C&D in association with GENUS PHARMACEUTICALS

Delivery of free NRT makes a difference

Lowering the cost and increasing the availability of nicotine replacement therapy would increase its use and success in all populations, researchers claim.

Posting free NRT to smokers who expressed a willingness to give up appears to increase the rate of smoking cessation, say the researchers in *The Lancet*.

When compared to those who expressed an interest in giving up but did not receive the patches, 33 per cent of NRT users contacted had successfully quit after six months, compared to 6 per cent of the other group. A counselling call also increased a patient's ability to quit.

Of the 34,090 eligible smokers who phoned the freephone number to obtain free NRT, over 6,000 successful quits were due to NRT with a cost per quit of $464 (approximately £250). Callers to the phoneline were from diverse backgrounds, which, the researchers say, appears to indicate "a large unmet demand for cessation assistance that keeps both cost and logistical barriers to NRT receipt to a minimum".

Barriers to giving up smoking seem to be cost and convenience

Other studies examining reduced cost NRT had mixed results, implying that the barriers are not limited to cost but also include convenience. "Some free NRT distribution efforts could still pose logistical barriers if smokers are asked to redeem vouchers, travel to a pick-up location, purchase additional medication or receive counselling to complete a course of treatment," conclude the authors.

For more information:

The Lancet 2005; 365: 1849-54

NICE guidance bars many from treatment, says cardiac charity

The latest NICE guidelines ignore a large section of the patient population, says a heart charity.

The British Cardiac Patients Association criticises NICE for its advice on using clopidogrel to prevent occlusive vascular events in patients intolerant to aspirin. It says the NICE guidelines "could prevent thousands of heart attack sufferers from getting effective treatment" and claims the guidelines are relevant and of benefit in "only a few" situations.

The charity claims NICE puts too much emphasis on aspirin and fails to recommend other available treatments in patients for whom aspirin is insufficient.

In addition, says BCPA, the guidance ignores the complexity of vascular disease by saying vascular events should be managed independently, despite NICE's acknowledgement they should be managed holistically.

Scriptlines

Inegy out

Merck Sharp & Dohme has launched Inegy tablets, a combination product containing ezetimibe 10mg and simvastatin 20mg, 40mg or 80mg.

Inegy is licensed for use in patients with primary familial and non-familial hypercholesterolaemia or mixed hyperlipidaemia where a statin alone has proved ineffective. The SPC states that patients using Inegy should be on an appropriate lipid-lowering diet.

Recommended dosing is 10/20mg or 10/40mg in the evening. The 10/80mg strength should only be used in patients with severe hypercholesterolaemia who are at high risk of cardiovascular complications. No dose adjustment is necessary in the elderly, mild hepatic or moderate renal impairment.

Price: 28s 10/20mg £33.42, 10/40mg £38.98, 10/80mg £41.21

Pip code: 10/20mg 313-6249, 10/40mg 313-6256, 10/80mg 313-6264

Merck Sharp & Dohme Ltd

Tel: 01932 467272

Kalten caps

[illegible] for Kalten capsules [illegible] hydrochlorothiazide and [illegible] has transferred from [illegible] to The Bolton Pharmaceutical Company 100 Ltd.

In addition, the product is now being distributed by M&A Pharmachem Ltd (tel: 01492 816814), though BPC100 says it is routinely available from wholesalers.

For more information:

The Bolton Pharmaceutical Company 100 Ltd

Tel: 0845 602 3907

Rectogesic

Rectogesic, a topical ointment containing 4mg/g (4%) nitroglycerin, has been launched by Strakan Ltd.

Licensed for the relief of chronic anal fissure pain, the ointment should be applied directly to the affected area twice daily for a maximum of eight weeks. The product works by relaxing the vascular smooth muscle around the anal canal to dilate peripheral blood vessels and promote healing, and provides pain relief for up to 12 hours, says Strakan.

Rectogesic is contraindicated for concomitant treatment with phosphodiesterase type-5 inhibitors such as sildenafil, and nitric oxide donors such as isosorbide dinitrate. Other patients for whom the product is unsuitable include those with hypotension, migraine, aortic or mitral stenosis, marked anaemia or closed angle glaucoma.

The SPC lists the most common adverse effect as dose-related headache, which occurs in 50 per cent of patients. Less common side effects noted in clinical trials include pain, nausea, vomiting, rectal bleeding and dizziness.

Price: 30g tube £32.80

Pip code: 316-3946

Strakan Ltd

Tel: 01896 668060

Seroquel starter pack

Seroquel 4 Day Starter Packs (quetiapine 25mg, 100mg and 150mg) are being discontinued on July 31, says AstraZeneca.

The company says it reached the decision following a review of its product portfolio. No other Seroquel products are affected.

For more information:

AstraZeneca Medical Information

Tel: 01582 836836

SPC changes

Changes to the therapeutic indications for Tavanic (levofloxacin) and Taxotere (docetaxel) have been announced by sanofi aventis.

Tavanic is now indicated for the treatment of chronic bacterial prostatitis, at a once daily dose of 500mg for 28 days. Taxotere is now licensed for the adjuvant treatment of patients with operable node-positive breast cancer in combination with doxorubicin and cyclophosphamide. In addition, Taxotere may be used in combination with trastuzumab for metastatic breast tumours that overexpress HER2, provided the patient has not already received chemotherapy for metastases.

For more information:

Sanofi Aventis

Tel: 01483 505515

Lamotrigine

Following the patent expiry of GlaxoSmithKline's anti-epilepsy medication Lamictal, generic lamotrigine tablets are now available from Alpharma, Arrow Generics, Focus Pharmaceuticals, IVAX, Ratiopharm, Pharmacological Corporation, Neolab, Teva UK, Pliva, Winthrop and Generics UK.

In addition, generic lamotrigine dispersible tablets have been launched by Ratiopharm, Teva UK, Pliva, Focus Pharmaceuticals, Winthrop and Arrow Generics.

For more information:

See *Price List*

Pfizer

LIPITOR
atorvastatin

Why choose anything else

Pure tissues offer allergy sufferers relief

Georgia-Pacific Corporation has developed tissues that contain less irritant dust than usually found in tissues.

Lotus Pure are 100 per cent pure soft, disposable cotton tissues which have received the Allergy UK 'Seal of Approval'.

The manufacturer claims that the product reduces irritant dust by up to 90 per cent and that this may benefit anyone suffering from a cold or flu as well as those who suffer from nose related allergies.

Hazel Argent, senior brand manager, comments: "Nose related allergies triggered by pollen, household dust and pet hair affect a staggering nine million people in the UK."

The tissues come in a pocket sized sealable plastic 'purepod' for added protection against transferable allergens that accumulate when tissues are left open. A refill pack is also available.

Price: purepod (8 tissues) £0.99; refill (6 packs) £1.99

Pip code: purepod 316-3979; refill 316-3987

Georgia-Pacific Corporation
Tel: 01204 673314

New distributor for Nad's

Ken Lamacraft Marketing has been appointed by Stage 2 to sub-distribute the Nad's hair removal range to independent pharmacies.

The Nad's range includes new pre and post depilation products as well as hair removal gel, creme and a facial wand to sculpt eyebrows.

For more information:

Ken Lamacraft Marketing Ltd
Tel: 01892 750888

Triple action message for Bisodol

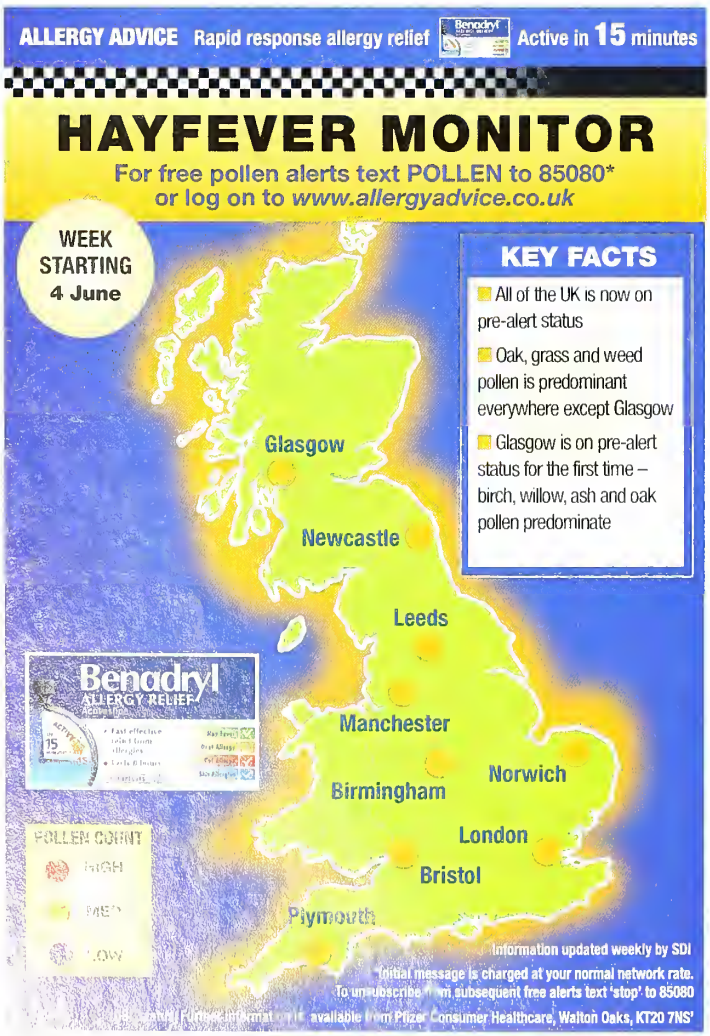
Forest Laboratories is introducing a new look for its Bisodol heartburn and indigestion remedy.

The new pack design retains the previous blue and yellow colours but has been updated to highlight the product's triple action.

A new Bisodol website *www.bisodol.com* has also been launched. The site provides information for sufferers about heartburn and indigestion including a 'hints and tips' section and links to other useful websites.

For more information:

Forest Laboratories
Tel: 01322 550 550



STRENGTH FROM A RANGE YOU CAN TRUST

NEW 250ML ADDS TO RANGE OF 500ML AND TABLETS

WHY RECOMMEND GAVISCON ADVANCE?

- [illegible]
- [illegible]
- [illegible] Gaviscon Liquid

GAVISCON
ADVANCE

[illegible]

Neon glow razor has the power

Gillette is extending its male shaving range with an eye-catching new battery-powered razor and a shaving gel on July 1.

The Gillette M3Power Nitro combines the technology of the M3Power razor with a stylish black and vibrant neon glow handle for visual effect. It is targeted at males in the 16 to 34 age group.

The razor sends micro-pulses to the shaving cartridge which helps to raise the hair to allow men to shave more thoroughly in one easy stroke, reducing skin irritation.

The PowerGlide blades feature an enhanced coating to provide improved glide and comfort and the Indicator Lubrastrip is infused with soothing vitamin E and aloe.

The razor launch is being combined with the introduction of Mach3 Nitro Gel to provide men with a complete solution for their shaving needs.

The launch will be supported by an advertising campaign starting on August 1. The campaign will include a new TV commercial focusing on the razor's performance and energy. Press, outdoor and internet advertising is also planned from August.

Price: razor £8.99; gel (200ml) £3.49

Gillette (UK) Ltd
Tel: 020 8560 1234

Dr Greenfingers patches brave kids up naturally

A range of natural first aid products especially for children is being introduced into independent pharmacies.

Dr Greenfingers is the brainchild of a group of parents who were concerned about the chemical ingredients that children are exposed to on a daily basis.

Manufactured for Dr Greenfingers by Weleda, the range comprises five products which are all 100 per cent natural.

It includes four products containing calendula – Cuts and Grazes Ointment, Antiseptic Patch-up Plasters, Antiseptic Wipes and Antiseptic Spray.

Also in the range is Bumps and Bruises Ointment which contains arnica montana.

The packaging features a character called Dr Greenfingers who is half human and half plant. Dr Greenfingers bravery award stickers for children are included in the packs.

Price: from £3.95 to £5.95

Dr Greenfingers Ltd
Tel: 020 8288 8484

Radox Shower makes a splash

Sara Lee is supporting the relaunch of its Radox Shower range with the brand's biggest ever TV campaign this summer.

The £5 million campaign will be on national TV for four weeks from June 10.

The commercial features a man taking a shower the morning after a heavy night out.

While he showers, his bathroom transforms into a Broadway stage, where his worst memories of the night before are replayed to him in the style of a musical.

After his shower, he feels better and can laugh at what happened.

For more information:

Sara Lee UK Ltd.
Tel: 01753 523971

TV

Anadin Extra: All areas

Benadryl: All areas except U, B

Breathe Right: GMTV

Cura-Heat: All areas except C4, five

Cura-Heat Period Pain: All areas except C4, five

Freestyle Mini: GMTV

Germoloids: C4, five, GMTV, Sat

Kalms Sleep: five

Rennie: All areas except CTV, CAR

TENA Lady: All areas except U, CTV, LWT, GMTV

PharmaSite for next week: Piriton – Window, **Piriton** – in-store, **Piriton** – Dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Rennie spells it out on TV

Bayer Consumer Care is backing its Rennie indigestion and heartburn brand with a £2 million national advertising campaign.

On air until July 24, the eight-week campaign features two commercials – one for heartburn and one for indigestion.

It is designed to reinforce the message that the brand offers fast and effective relief from the discomfort and inconvenience associated with these conditions.

New point of sale merchandising units for Rennie are also available.

For more information:
Ceuta Healthcare
Tel: 01202 780558

SCA steps up Tena protection

SCA Hygiene Products has improved Tena Pants Discreet to provide better security for people with bladder weakness.

The pants feature a 'dry fast core' and are designed to be breathable, comfortable and more absorbent than before.

Suitable for both men and women with light to moderate leakage, the pants can be worn under all types of clothing just like normal underwear.

A new TV commercial featuring the improved pants will be on TV this month as part of a £4 million advertising campaign for the brand this year.

The advertising coincides with Men's Health Week (June 13-19) which aims to increase awareness of health issues among men including prostate cancer, BPH and obesity which are all common triggers of bladder weakness.

Over four million people in the UK, including at least two million men, experience bladder weakness.

For more information:
SCA Hygiene Products Ltd
Tel: 01582 677400

Aloe to a triple blade shaver from BIC

BIC is launching a triple blade one-piece shaver to encourage consumers to trade up from a twin to a triple blade shaver

BIC 3 features triple blade technology for a close shave and a lubricating strip with vitamin E and aloe strip for smooth shaving.

"The triple blade one-piece market is booming, with 48.3 per cent year-on-year sales growth in 2005," says Joanne Potter, BIC category marketing manager.

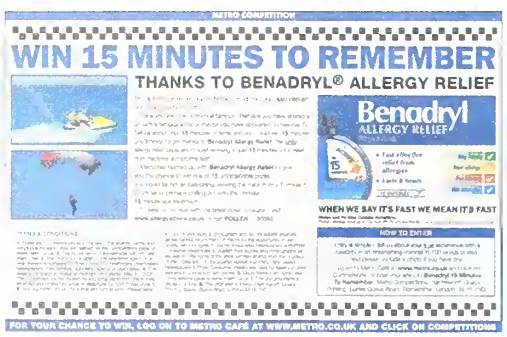
The shaver is available in packs of four and eight.

Price: £1.99 (4); £3.59 (8)
BIC (UK) Ltd
Tel: 01895 827100

Top celebrity stories can win 15 minutes of fun

Benadryl has linked up with *Metro* newspaper for a national competition and promotional campaign during the hay fever season.

The competition invites *Metro* readers to reveal their 15 minutes of fame experience with a celebrity to link with Benadryl Allergy Relief's 'active in 15 minutes' message.



The 15 best entries will win prizes that guarantee an unforgettable 15-minute experience including hot air ballooning, flying an aeroplane and a luxurious spa treatment.

The best entries and the winners will be showcased in *Metro* on June 9.

The competition is being supported with advertising outside Underground stations plus activity on regional radio stations.

For more information:
Pfizer Consumer Healthcare
Tel: 01304 616161

Adjustable insoles gel with customers

SSL International is introducing gel arch supports into its Scholl insoles range.

Scholl Adjustable Gel Arch Supports feature a system of interchangeable gel inserts which are easy to insert, remove and change.

The system allows customers to choose the appropriate level of support they need underfoot.

The insoles offer cushioning for flat feet and weak or fallen arches. Suitable for men and women, the insoles are available in sizes four to nine.

Price: £12.99
SSL International Plc
Tel: 0870 122 2690

Brand Focus

Wartner – wart and verruca remover

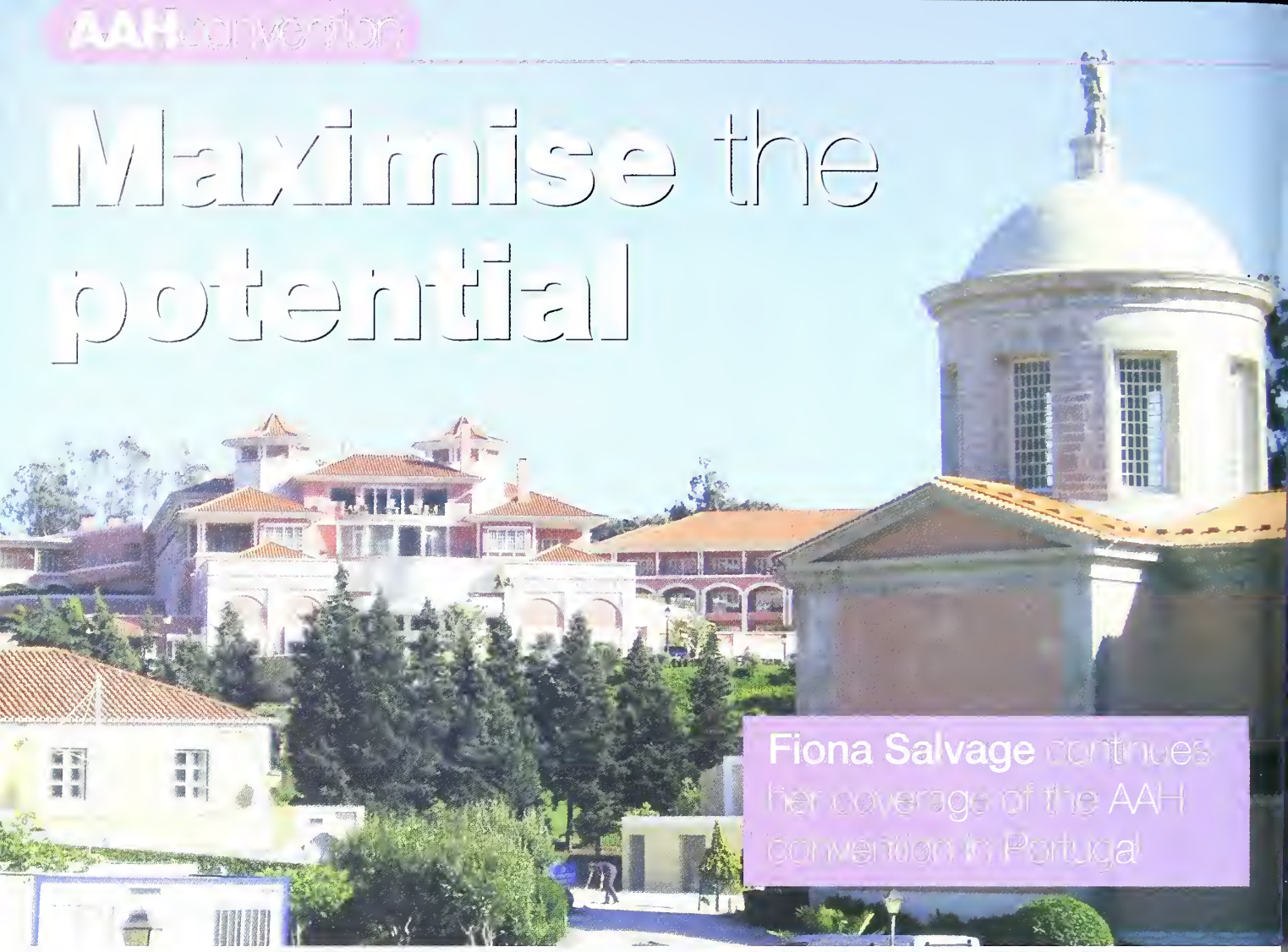
Chefaro UK, part of Omega-Pharma, is a leading international health and beauty company with a broad portfolio of OTC brands.

Warts and verrucas are benign but contagious skin tumours caused by the human Papilloma virus. The majority of OTC treatments are based on salicylic acid, however these treatments can be quite messy and take up to 12 weeks.

Wartner is safe, effective, easy to use and treats warts in just 20 seconds. Based on the liquid nitrogen method used by GPs, Wartner works by rapidly freezing the core of warts and verrucas. Just a single 20-second treatment is usually enough. Further information is available on the Wartner website:

www.wartner.co.uk

Maximise the potential



Fiona Salvage continues her coverage of the AAH convention in Portugal

Steve Dunn, group managing director of AAH Pharmaceuticals, introduced the second day of speakers at the wholesaler's convention with the theme of "maximising the potential for pharmacy".

One potential opportunity for pharmacy lies in independent prescribing and filling the gaps left by GPs opting out of out-of-hours cover, he suggested. However, he lamented the lack of a unified voice for pharmacists to promote the pharmacy profession's abilities to provide these services. "It will have to be you then!"

Pharmacy has done it before with the threat of control of entry, he said, adding: "Why should it be less so regarding engagement with the NHS and PCTs? Surely this is an opportunity for pharmacy to lobby for extra payment for covering on Saturdays when GPs are closed."

Does policy herald a **golden** age?

Could this be pharmacy's golden age, asked Clive Jackson, chief executive of the National Prescribing Centre. The Government's policy to target management of long-term conditions has come out of nowhere in 18 months to become a top priority, he said. Add to this the self-care agenda that "community pharmacy is clearly in a very good position" to assist with, in addition to playing a monitoring and support role within disease management. This can be helped by healthcare and social care budgets merging and the opportunities new prescribing opportunities offer.

Mr Jackson predicted the number of non-medical prescribers will outnumber medical prescribers by the decade's end. Adding into the equation are specialists within community pharmacy, such as pharmacist prescribers, pharmacists with a special interest (a focused group like GPs with a special interest) and a new professional tier of consultant pharmacists.

"Much of this depends on the skill mix and housing the use of pharmacists between professions and within pharmacy, he warned. And there are some changes to watch out for in professions allied to pharmacy. With the PCTs' commissioning framework changing, new pots of money and commissioning opportunities will open up. Payment by results "has the potential to take services out of hospitals and put them into primary care, such as diagnosis and follow-up" he explained. "GP practice-based commissioning is one to watch. Once GPs start commissioning services they will have considerable say in how services are configured in the locality."

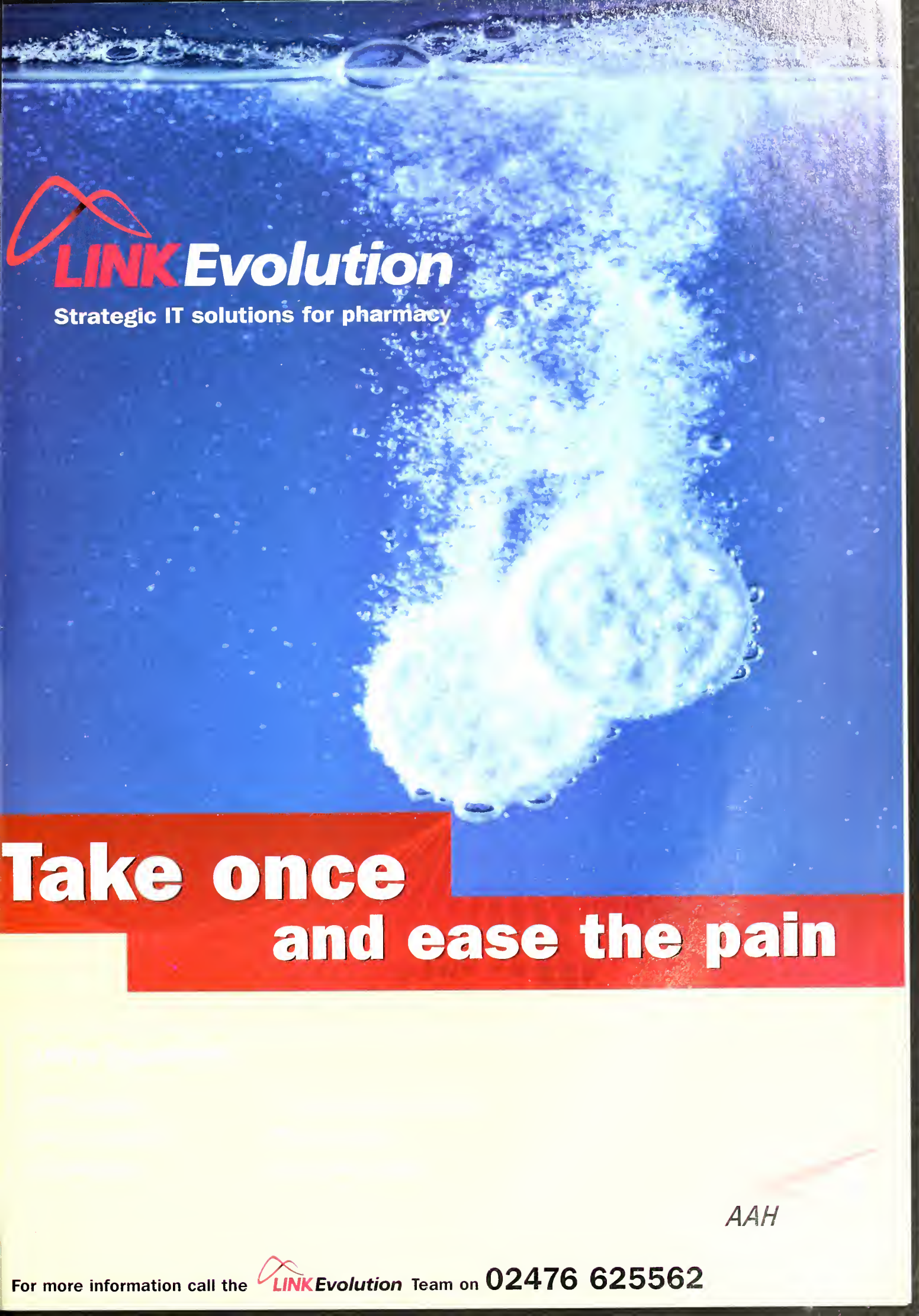
Clive Jackson: "The contract is not the only route by which services can be delivered"

Another prediction he offered was for alternative providers of medical services (APMS): "I think the time is about to come for this." He said he can see a move to include the role of APMS-type services, but warned: "The contract is not the only route by which services can be delivered."

Thinking outside the old box means "what does the commissioner [of services] want and need? What do the patients need? Use surveys and evidence to find out. What do other professionals think? Where is pharmacists' expertise best utilised?"

Pharmacists could have patient advocacy and co-ordinator roles across health and social care, he suggested. Working on concordance, care in the home settings, medicines use reviews and formal and informal support for

Continued on page 36


LINK Evolution
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Take once
and ease the pain
AAH
For more information call the LINK Evolution Team on 02476 625562

carers are all possibilities. Looking at prescribing, he said there are potentially five or six ways patients will be able to get their medicines. The increase of 'counter prescribing' possibilities with the shift of status from POM to P offers "a significant move in the pipeline to enhance a disease management role, for example in cardiovascular disease management", he said. In addition there are Medicines Act extensions, patient group directions (one PCT surveyed had 763 PGDs), supplementary prescribing and independent prescribing which "is on the horizon". It's a "really big opportunity," he said. "You need to look at this as this will impact on the future."

Being aware of what is in the future is important, even if it seems a long way off. The future of genetic and genomic developments will impact on medicines: "There will be revolutions in a 10 to 15-year period in the way medicines are given, such as finding out who responds to tricyclic antidepressants. If it's done in the high street, who will do it? It could radically change the way medicines are delivered. If you're not thinking, the world will change beneath you and you're not in the game," he warned.

"If you're underestimating what is happening in the health service now, you're in big trouble. This is the biggest single change in the health service since 1948." And it's the most exciting time in pharmacy for a generation. "You need to think carefully about specialisation: it will be a big feature for a substantial proportion of the profession."

Steve Duff, group managing director of AAH Pharmaceuticals, closed the convention's business sessions. He criticised the Government's pressure on the pharmacy supply chain, adding: "I would claim that, if they continue to bear down on manufacturers, wholesalers and pharmacists [illegible] 2006 [illegible] drugs will [illegible] pharmacy [illegible]

Customers get **smarter**

Simon Gulliford: "Staying still is not an option"

Simon Gulliford, chief executive of the London Business School, made entertaining and illuminating presentations on each of the two days of business sessions. He offered the delegates pearls of wisdom from his career in marketing companies such as Selfridges and Barclays Bank. Customers are getting smarter, he warned. "You cannot rely on the consumer staying stupid. Customers are getting smarter and more informed at a rate of knots," he said. "Merely staying still is not an option: the customers' perception is that things are getting worse as their expectations have increased."

The larger companies don't have it better, necessarily. "Frequently large organisations have an arrogance that scale provides. Small companies are closer to the communities and can be quicker to respond. Often size mitigates against the provision of consistently good service."

One way of offering good service is having a deep appreciation of the factors which have a bearing on satisfaction. A consumer wants a quick acceptance of their problem, he explained. "You need to remember about them [customers] – they will pass it on to friends when they have had good advice." However, "good just isn't good enough if you want to build loyalty: people want excellence because they have a choice".

Differentiation is important, he explained. "It is better to be first than it is to be better." If you can't be first in a category, set up a new category in which you can be first, he explained. However, you will need to manage expectations and not just capacity, he warned.

Mapping out the future

Mandeep Mudhar, AAH's marketing director, announced to delegates the company's schemes for helping pharmacists with the new contract. First, Dr Mudhar revealed AAH's *Guide to the New Pharmacy Contract: Navigating the New World*, which is available to all AAH customers. It covers the requirements for pharmacists in England and Wales to provide essential services. Solutions for pharmacists in Scotland and Northern Ireland are currently being developed.

The current pack will provide SOPs for services such as repeat dispensing, templates for referral letters, and advice and training for health awareness campaigns. However, Dr Mudhar warned pharmacists they must engage their whole team for the contract to work: "You will not deliver the new contract successfully if your staff are not fully engaged and have clear areas of responsibility."

The whole team must be engaged for the new contract to work

One of the most important essential services is clinical governance, he said, and the pack offers checklists and guidance to assess current levels and recognise gaps. AAH has also teamed up with De Montfort University's postgraduate pharmacy school to provide a distance-learning support programme, which is available to all AAH customers.

It contains a CD-Rom that offers training, advice and processes that can be put in place.

In addition, he announced AAH's support for advanced services such as MURs. AAH has teamed up with Medicines Partnership to help patients understand the importance of medicines use reviews. Co-branded booklets to be used with patients to improve compliance have been sent to pharmacies.

Moving on to enhanced services, Dr Mudhar revealed AAH's offering to its customers in that area. It will be offering a team of AAH personnel who will negotiate on pharmacists' behalf with primary care organisations for commissions of enhanced services. AAH is offering a service in this area because, he said, "we have for some time sat back and watched what is happening in this area. And frankly, what we see concerns us. We see some but not all PCOs engaged with pharmacy. We see some, but not all, local pharmacy bodies talking to PCOs. And what we don't see is a consistent dialogue or proposition being made to PCOs or PCOs agreeing to any robust long-term services through pharmacy."

He concluded by saying that AAH will continue developing innovative solutions to help its pharmacists in "this ever-changing marketplace".

You'll do my girl

Maureen Furmedge has worked in a Portsmouth pharmacy for 40 years. William Tremlett reviews her career

When Maureen applied to my father – Dick Tremlett – at his Fratton Road Pharmacy in 1965 for a part-time job, little did she realise what the future would bring…

Father's interview technique was a little unorthodox. Once he had decided that Maureen was suitable for the job, he told her: "You'll do my girl, start today." There was no discussion of wages or employment contracts. After all, these were the days of retail price maintenance and kaolin poultice, and the war attitude still persisted.

Initially trained at Boots in Lake Road, Portsmouth, Maureen and her husband Arthur left the city to work in Oxford where she taught typing. When they returned to Portsmouth, Maureen joined Tremlett's part-time to fit in with her working husband and their two young sons Stephen and Peter. Maureen quickly proved herself a capable, knowledgeable, but above all cheerful, member of the team, always ready for a joke. At this time the new pharmacy technician's course was starting, and she tackled it with gusto to pass with 90 per cent.

After the retirement of Paddy O'Connor, who had run the dispensary since 1946, Maureen was immediately made captain of the Tremlett ship at Fratton. It was at this time that drug purchasing became more and more important to pharmacy, and Maureen accepted the buyer's role, alongside her other duties, with her normal enthusiasm and cheerfulness. Her ruthlessness in bargaining soon led to respect and fear from representatives, as she wielded the group's purchasing power. Lost for hours in the generic/PI storage area, known as 'the cage', we always knew where to find her, locked in heated discussions with some poor hapless rep.

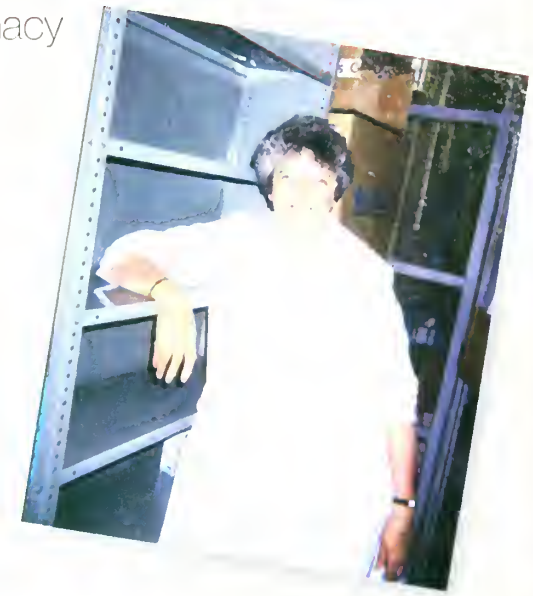
During her time Maureen has seen some notable events, including the moving of the store from 2b Fratton Road to its current site at 94-98 Fratton Road in 1975; Champagne on the roof when the Queen came down the road in 1977; the centenary celebrations of the company in 2001; and the sale of Tremlett's to Rowlands in 2002. Staff have come and gone, some even returned, but her long-term friend and colleague, Ruby Pullen, has been at the branch even longer than Maureen. It is people like these two who give Fratton its character.

Like many of her generation, Maureen has lived through the 'therapeutic revolution' – the early days of making everything from mixtures, lotions, suppositories, pessaries and powders to ointments and creams has been replaced by the proprietary liquids and solid dose forms. These are more effective at treating diseases such as diabetes, blood pressure and infection than her predecessors could have ever imagined.

But along with the rest of the profession, she has learnt the heartache and difficulties imposed upon patients by modern drugs, such as thalidomide. The improvements, though, have been significant and Maureen's work life, so far, has seen medicines reach a state that our grandfathers or even fathers could not have forseen, and the next generation of drugs will be even more exciting. This huge amount of background knowledge and experience makes Maureen an invaluable source of expertise in comparing old drugs with new.

Furthermore, pharmacy technicians are at last being recognised as experts in their own field, and it is encouraging to us all that Maureen is now taking up the challenge of becoming a checking technician.

Maureen's family have always been the mainstay of her life and with one of her grandsons (Daniel) working in the holidays with her at the pharmacy, while studying medicine at King's College London, she will be imparting this knowledge for some time to come, it seems.



Maureen Furmedge in the Fratton Road pharmacy in Portsmouth today, and below, earlier in her career

Breaking the junk food habit

The state of children's nutrition hit the headlines earlier this year. Sarah Purcell looks at the dietary needs of children and how pharmacy can contribute to improving the nation's health

When school dinners hit the headlines we were all shocked to discover that just 37p was spent per child per day on ingredients out of the £1.50 a day that most parents pay. Given that meagre sum, it was hardly surprising that few schools were providing nutritious, well-balanced meals made from fresh ingredients.

And while celebrity chef Jamie Oliver did a fine job in starting off a much-needed debate on food quality in our schools, he was the catalyst for something even more important. The school dinner furore has also helped to get parents to look more closely at all the food their children eat (not just at school) including at home, where patterns for life are set.

So what's been going wrong with our children's diet and how can you help put it right? The Channel 4 series *Jamie's School Dinners* got the whole nation talking about what children were (and weren't) eating and helped to speed up Government plans to ditch junk food in schools. Over the next three years £220 million new money is being given to schools to improve meals, with a strong emphasis on healthy, freshly cooked ingredients. Schools will be given money to improve or build school kitchens, train kitchen staff and buy fresh ingredients.

A survey carried out by the Government to find out what children were eating in secondary schools produced some worrying findings:

- Cakes and muffins were the most commonly served foods in schools – 95 per cent served them four or more days a week.
- Chips were served four or more times by 76 per cent of schools and chicken nuggets and pizza by 56 per cent.
- 72 per cent of schools served soft drinks and 40 per cent didn't have fruit juice as an option.
- Only 3 per cent of schools provided set meals over the course of one week that met eight or more of the guidelines for healthy school meals. The guidelines most meals fell short on were lack of iron, calcium and percentage of energy from carbohydrates.
- Some 48 per cent of children chose a high fat main dish with chips while their least popular choices were fruit (only 2 per cent chose this), fruit juice (3 per cent) and vegetables and salad (6 per cent).
- Around 41 per cent of the energy from school meals came from fat, with 14 per cent of that being saturated. The guidelines recommend that 35 per cent or less should come from fat and less than 11 per cent of that should be saturated fat.

The good news is that tougher standards are now to be introduced in schools to improve what children eat and experts believe that by improving what our children eat their concentration and performance at school will get better too.

Tougher standards are now to be introduced

At the British Nutrition Foundation nutrition scientist Sarah Richards is helping to organise a conference on food in schools this month, gathering together experts in the field. "We're looking into opportunities for healthy eating throughout the whole school

day – not just lunchtime. We'll look at ways to get healthier food into breakfast clubs, tuck shops, packed lunches, cookery clubs and in the curriculum itself. We want to help children learn to make these healthy choices for themselves."

Causes for concern

Here are the aspects of our children's diets that worry the experts most:

Fat intake: "While children are eating enough calories for growth and energy, too much of that is coming from saturated fat sources," says Ms Richards.

The National Diet & Nutrition Survey found that children were eating similar levels of saturated fats to adults. "A lot of the fat they eat comes from crisps and chips," says Tom Sanders, professor of nutrition and dietetics at King's College Hospital, London. "Parents can substitute real chips for oven chips, which are much lower in fat, and limit crisps to once or twice a week."

However, fat intake hasn't actually increased in the past two decades. "Children are getting about 35 per cent of energy from fat, which is the same as 20 years ago. The difference is that activity levels have decreased dramatically, which is why we have the obesity issue," says Anita Macdonald, head research dietician at Birmingham Children's Hospital.

Salt consumption: "With children it doesn't tend to come from table salt but hidden salts in foods they eat daily, primarily crisps, bread and breakfast cereals. Parents are often surprised by this as they assume bread and cereals are healthy choices." Children are thought to consume twice as much salt as they need every day and experts are worried about the effect on their long-term health.

These are the new recommendations for children's maximum salt intake per day: 0-6 months: <1g; 7-12 months: 1g; 1-6 years: 2g;

Continued on page 42 ▶

What do children need?

Iron: Two in five 15 to 18 year old girls have low iron levels, which left unchecked could lead to anaemia, but 43 per cent aren't aware that a lack of iron could have health consequences. Of those surveyed by the Food Standards Agency, 68 per cent had experienced symptoms of low iron levels – tiredness, looking pale, feeling faint and breathlessness.

It's not just teenagers who are lacking in iron. "It's the most common deficiency we come across in young children, especially among those aged six months to two years. You might notice tiredness and irritability and there's some debate on whether it interferes with congnitive development. It certainly needs to be treated with medication," says Anita Macdonald.

Good sources include fortified breakfast cereals, red meat, baked beans, leafy green vegetables, dried fruit and canned sardines.

Teenagers should be eating 14.8mg of iron a day.

Calcium: children should be eating plenty of calcium-rich foods for bone and tooth development. Lots of children go off milk by the time they start school, so other good alternative sources include yoghurt, yoghurt drinks, cheese, broccoli, cabbage, bread and anything made with fortified flour.

"Teenage girls can often lack calcium because they're avoiding dairy products. Parents can help by substituting semi-skimmed milk and half-fat cheeses," says Professor Sanders.

Fish: if you can persuade them to eat it, two portions of fish a week are good because fish are a good source of protein, vitamins and minerals and they are low in saturated fat. Oily fish, such as mackerel, salmon and sardines, also contain omega-3 fatty acids.

Vitamin C: good sources are citrus fruit, tomatoes and potatoes. Vitamin C may help the absorption of iron, so having fruit juice with an iron-rich meal will increase iron absorption.


Banana smoothies are a great way to get calcium

Vitamin A: this is important for good vision and healthy skin. Milk, margarine, butter, green vegetables, carrots and apricots are all good sources.

Protein: children aged four to six need about 15 to 20g protein each day and those aged seven to 10 need about 23 to 28g protein a day. Good sources include poultry (an average portion of roast chicken breast contains 27g protein), lean meat, tuna, cheese (an average cheese sandwich on white bread contains about 17g protein), eggs, milk and bread.

Fresh fruit and vegetables: children should be eating five portions of these each day too.

Arthritis and related conditions are the second most common cause of absence from work, making any safe and effective treatment highly desirable

More than 7 million adults in the UK – some 15 per cent of the population – have long-term health problems due to arthritis and related conditions. This is one of a depressing series of statistics flagged up by the Arthritis Research Campaign[1] that emphasises the human cost of the disease.

More than 2 million people will have visited their GP in the past year because of osteoarthritis, ARC estimates. Since the disease is more prevalent in the elderly, more people will be seeking medical help in the future as the 'grey wave' comes to dominate the demographic curve.

Another contributory factor to the increase in GP visits is growing levels of obesity – a major risk factor for osteoarthritis of the knee. The UK currently has the eighth highest obesity rate in the world. Since obesity predisposes individuals to many other health problems apart from arthritis, it is little surprise that diet and exercise are high on the public health agenda.

The statistics roll on… at least 4.4 million people in the UK have x-ray evidence of moderate to severe osteoarthritis in their hands; 550,000 are affected in their knees and 210,000 have moderate to severe osteoarthritis of the hips, suggests ARC.

The cost to the nation of arthritis and related conditions is pretty depressing too: 206 million working days lost in 1999-2000 – the second most common cause of absence due to illness after mental disorders. In 2000 the cost of GP consultations was £307m, the cost of prescribed drugs £341m, and secondary care rheumatology costs (including hip and knee replacements) was £664m. Add to this the cost of disablement allowances and community and social services and the total figure comes to around £5.5 billion.

The Arthritis Research Campaign is, of course, seeking to make a point. Its definition of arthritis and related conditions includes all conditions that affect the bones, joints and ligaments, such as arthritis of all kinds, connective tissue diseases, back pain, and osteoporosis. And the point it is seeking to make is that despite the growing size of the problem, resources to tackle it are not keeping pace. NHS expenditure on arthritis increased by only 5 per cent between 1990 and 1999 compared with an increase of 19 per cent in the total NHS budget.

Osteoarthritis factfile

- **Osteoarthritis (OA) is the most common form of arthritis. The incidence increases with age and at least 50 per cent of people over 65 years have radiographic evidence of OA[2] Approximately 30 per cent of people over 60 years have knee pain, and more than 10 per cent of people over 65 years have major disabilities due to OA. OA is three times as common in women compared to men.**
- **OA is a progressive disorder of articular cartilage affecting the joint cartilage and underlying bone. Any joint may be affected. It should not be considered as simple wear and tear. It is a metabolically active process usually beginning in middle age. Progressive loss of articular cartilage is usually observed, with new bone formation in the subchondral trabeculae, and formation of new cartilage and bone at the joint margins.**
- **It is predominantly a non-inflammatory condition so management of the condition centres around relieving the pain, slowing progression of the disease and improving mobility. Weight reduction, gentle exercise and warmth backed up by simple analgesics is the standard approach. Paracetamol (up to 4g daily) taken regularly is the drug of choice. Non-steroidal anti-inflammatory drugs may have a role in advanced OA where inflammation is present.**

Glucosamine – a complementary option?

Around one in four of people who suffer from arthritis and joint pain have used some form of complementary medicine – homoeopathy, acupuncture, a herbal product or glucosamine – to treat their condition . The proportion rises to 33 per cent for those with osteoarthritis.

Glucosamine has attracted considerable attention as a treatment for arthritis. *Bandolier*, a publication that prides itself on scrutinising the evidence base that supports any medical claim, has concluded that: "Evidence that glucosamine (and chondroitin) is effective in osteoarthritis continues to build. We now have two top class reviews of older, short studies that come to this conclusion, and a new randomised trial of some quality that demonstrates a clear disease modifying effect.".

The trail referred to by Bandolier was a three year randomised study with 212 patients over 50 with primary knee OA. Subjects were given 1,500mg oral glucosamine once daily or placebo. The primary outcome was the mean joint space width of the tibiofemoral joint (a measure of disease progression). Pain, functioning and analgesic usage was also measured.

The average joint space width was about 5.4mm at baseline. With placebo there was a mean narrowing of 0.3mm over three years: with glucosamine there was no narrowing. Glucosamine also improved pain and function markers by 20-25 per cent, while there was no improvement with placebo.

Another large randomised double-blind placebo controlled trial, sponsored by the US National Center for Complementary and Alternative Medicines, is expected to report in November 2005 . The glucosamine/chondriotin arthritis intervention trial (GAIT) has recruited over 1,500 subjects, and will determine whether glucosamine, chondriotin sulphate and/or the combination of both are more effective than placebo in treatment of pain associated with arthritis of the knee.

Glucosamine is an amino sugar and is thought to promote the formation and repair of cartilage. Chondriotin is a carbohydrate and a component of cartilage that is thought to promote water retention and elasticity, and to inhibit the enzymes that break down cartilage. Both compounds are manufactured by the body.

Trials of glucosamine are hindered because there is currently no international pharmaceutical standard for the compound. Glucosamine is available as a variety of salts, typically sulphate and hydrochloride. There is little evidence that one form is better than another, or the impact on product formulation and stability.

However, from a safety perspective, no studies have identified any serious side effects from either glucosamine or chondriotin supplements.

Eating

It's well known that diet is closely linked with risk of heart disease along with obesity and lack of exercise. But what's the latest thinking on the most important nutrients to include and foods we should be eating less of to protect our hearts?

- **Fats:** The British Heart Foundation recommends that our diets contain no more than around 30 per cent fat, and of that saturated fat should be kept to a minimum.

"Reducing your intake of saturated fat and swapping it for monounsaturated and polyunsaturated is the most important thing you can do for your heart health," says Judy O'Sullivan, cardiac nurse at the BHF. "And when choosing spreads, go for one with the lowest content of trans-fats." It's thought that reducing saturated fats can reduce cholesterol levels by 5–10 per cent.

There's some evidence that eating spreads enriched with sterols and stanols can help reduce cholesterol too, and these can be useful for people at risk of heart disease who can't take statin drugs.

- **Fish:** oily fish is one of the healthiest foods for your heart as it's a rich source of omega-3 fatty acids which have a protective effect on the heart. It reduces blood pressure and the tendency of blood to clot, regulates heart rhythm and reduces triglyceride levels.

"You should try to eat two portions of oily fish a week – mackerel and trout are the best sources," says Ms O'Sullivan. "For people who don't like fish it's fine to take a fish oil supplement containing 1g of omega-3 instead, or to get the omega-3 acids from plant sources like flaxseed oil and linseed oil."

Oily fish are a rich source of omega-3 fatty acids

7–14 years: 5g; Above 15 years: 6g.

- **Sugar consumption:** "Children get most of their sugar not from pure sugar but foods and drinks that contain it, primarily fizzy drinks, cakes, biscuits and chocolate. However, we're not telling children that sugar is a bad food they should never have, it's just the frequency of consumption we need to limit," says Ms Richards.
- **Fruit and vegetables:** one in five children eat no fruit in an average week and few eat the recommended five portions of fresh fruit and vegetables in a day.

One in five children go to school on an empty stomach, which means they're more likely to fill up on unhealthy snacks mid-morning and concentration suffers. Research has also shown that children who skip breakfast are more likely to become overweight and lacking in calcium.

One in five children go to school on an empty stomach

Children who eat breakfast perform better in tests and have fewer behavioural problems in school. "We know that children can get 25 per cent of their micronutrient intake from breakfast cereal, as well as calcium from the milk. It's also a good source of fibre," says Professor Sanders. "You can improve children's iron absorption by giving them a glass of fruit juice with their breakfast."

A place for supplements?

All children between six months and five years could benefit from taking drops containing vitamins A, C and D. These will help to make sure that they get these important vitamins, particularly if they aren't eating a varied diet.

"Older children and teenagers can benefit from a multivitamin if they're faddy eaters or are vegetarian but not eating the right foods," says Professor Sanders.

There has been much publicity about the use of fish oil supplements for children, in particular to aid concentration, and feelings are mixed on how useful these are. Nutritionists and dieticians argue that getting children to eat oily fish is far better than giving them a supplement, because as well as the omega-3 oils it contains there are lots of other nutrients in fish they could benefit from too.

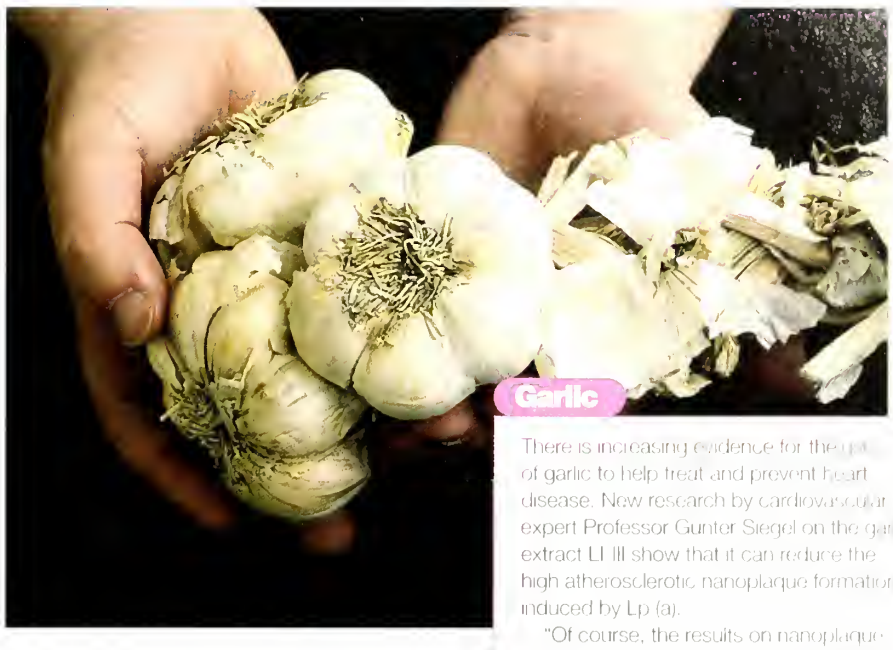
Many parents will testify that it's not always easy to persuade children to eat oily fish. "It's true that lots of children won't touch oily fish and this is one reason why fish oil supplements have become so popular. However, food manufacturers are now looking into ways of getting this useful oil into other foods too, and we could see this happening in the next few years," says Ms Richards.

CPD

This article can help in the following areas of competence as set out in the RPSGB's CPD manual: G1q, C2a, C2c

for **heart health**

- **Salt:** "Our bodies only need around 2g of salt per day, and the maximum recommended amount for adults is now 6g per day," says Ms O'Sullivan. Reducing salt intake helps to lower blood pressure, which in turn cuts the risk of heart disease and stroke. Researchers at Addenbrookes Hospital found that adults who consumed 5g of salt per day halved their risk of hypertension.
- **Fruit and vegetables:** "We know that fresh fruit and vegetables have antioxidant properties that help to reduce cholesterol and cut the risk of heart disease," says Ms O'Sullivan. It's also believed to lower blood pressure too. We should aim to eat five to seven portions per day.
- **Folates:** there has been some research to link increased folic acid intake with the reduction in homocysteine levels, which are raised in people with heart disease. So should we be taking folic acid supplements? "We're not sure yet why lowering homocysteine levels benefits heart health or how low the levels need to be to protect it. But there is a lot of research going on into this at the moment," says Ms O'Sullivan. She advises eating foods rich in folates such as green leafy vegetables, root vegetables and nuts.



For more information on heart health, the following may be helpful: 'Cardiovascular disease: diet, nutrition and emerging risk factors', a report by the British Nutrition Foundation task force (Blackwell Publishing).

Garlic

There is increasing evidence for the use of garlic to help treat and prevent heart disease. New research by cardiovascular expert Professor Gunter Siegel on the garlic extract LI 111 show that it can reduce the high atherosclerotic nanoplaque formation induced by Lp (a).

"Of course, the results on nanoplaque build-up have to be confirmed in a clinical trial," said Professor Siegel, "but a positive outcome of such a study would complement the already existing clinical studies."

Nutrition product news

Icaps eyes up the over 50s

ICaps is targeting the over 50s to promote the vitamin supplement's role in eye health maintenance.

Research suggests that eye health is a low priority for the over 50s compared to other age-related health worries. The campaign will run through to July and will include advertorial coverage in the consumer press as well as a sampling programme in leisure centres, directly targeting the over 50s.

ICaps contains lutein and zeaxanthin, nutrients which naturally occur in the macula and which reduce oxidative stress in the eye, as well as helping absorb damaging blue light, says the company.

Alcon Laboratories
tel: 01442 341234

Bone health

With June being National Osteoporosis Month, Wassen is raising awareness of the role of nutrition as an important part of its management.

It is also warning of the potential problems in pre-menopausal women, with 75 per cent of low risk younger patients having low bone density scan readings.

Wassen supports the National Menopause Advice Service, with an educational grant, which carries an information sheet on osteoporisis on its website, www.nmas.org.uk.

Wassen International Ltd
tel: 01372 379828

Young take to the Seas

Some 48 per cent of adults now take VMS on a regular basis, and multivitamins are a popular choice. Seven Seas is promoting its probiotic multivitamin Multibionta to a younger audience and has grown its share of the multivitamins market by 16 per cent in the past year.

Seven Seas, tel: 01482 375234

Pine bark extract helps asthma

A study published in the *Journal of Asthma* found that pycnogenol, found in pine bark extract, can help to control children's asthma. It's thought to prevent the bronichi from constricting and swelling and the children who used it in the study were able to reduce usage of their inhalers. Bio-Pycnogenol 40mg comes in packs of 90 or 150 tablets.

Pharma Nord, tel: 01670 519989

Osteoporosis reminder

June is National Osteoporosis Month and aims to raise awareness of the condition and alert those who may be at risk of developing it. It will also highlight the importance of consuming enough calcium for bone health. BioCalth is a calcium L-threonate supplement that helps to enhance bone and cartilage cell functions, assist collagen and bone formulation and helps maintain joints and mobility.

BioCalth UK
tel: 01756 790009

The three omegas

Lifeplan's Organic Omega Blend contains a mix of omega-3, 6 and 9 fatty acids to promote heart health. It includes flaxseed oil, high in omega-3, hemp oil, which is a good source omega-3 and omega-6, sesame oil which contains omega-9 acids, pumpkin seed oil, high in omega-3 and 6, and evening primrose oil.

Lifeplan Products
tel: 01455 556281

Soft and chewy way to health

All children under five are recommended a daily multivitamin, especially if they are faddy eaters. Bassett's Soft & Chewy ACD & E are a tasty way to ensure that children get all the vitamins they need. The pastilles are easy to chew, sugar-free, in orange or strawberry flavour and have fun jelly baby faces on each one.

Ernest Jackson
tel: 01363 636000

Taking care of those joints

Joint protection is an important sector of the 50+ market and Seven Seas JointCare products now claim a 33 per cent share of this growing market. The brand is to be backed by strong promotional support for the rest of the year.

Seven Seas
tel: 01482 375234

Numark does well on its own

Numark saw its own-label VMS sales grow by 31 per cent last year, but believe that many pharmacies don't give the category enough shelf space.

"Every pharmacy should have a representation within this category. Customers are becoming increasingly health aware, which means they no longer necessarily rely purely on allopathic remedies. For some people medicines may not always be suitable, so they are more likely to turn to VMS and CAM for alternative solutions," says category development manager Emma Betts.

NVS Ltd, tel: 0207 486 0580

Chew it and see

Seven Seas Haliborange DHA Concentration Omega 3 Fish Oil for children has grown the omega-3 children's market. Chewy capsules are available along with the syrup.

Seven Seas
Tel: 01482 375234

Bio-Sport fights tendon injuries

A study published in *Physical Therapy in Sport* has shown how the supplement Bio-Sport can help to treat tendon injuries, especially those brought on by overuse in sport. In a trial, sufferers were able to increase their activity level by 53 per cent after a month while pain was decreased by 99 per cent. Bio-Sport contains omega-3 and omega-6 fatty acids which are thought to reduce inflammation.

Pharma Nord
tel: 01670 519989

Enzyme helps heart health

Cardiozen is a blend of omega-3 fish oil and CoQ10 for heart health protection. CoQ10 is an enzyme that helps cells to remain active and is especially important for heart health. One of the side effects of taking statins to lower cholesterol is that it can interfere with the body's ability to produce this enzyme as well as lower omega-3 levels in the blood.

Chemist Brokers
tel: 023 9222 2500

Garlic gets the seal of approval

New research has strengthened the case for garlic in helping to prevent and possibly reverse arteriosclerotic plaque formation. At a conference help by the American Heart Association in April, cardiovascular expert professor Gunter Siegel announced his findings which show for the first time that Kwai garlic can reduce the incidence of nanoplaque formation by up to 40 per cent and their size by up to 20 per cent. There are three products in the Kwai range: Kwai Original, Kwai Once-a-Day and Kwai ACE.

Lichtwer Pharma,
tel: 01628 487780

Tasty Eye Q

Equazen's Eye Q Smooth has been featured in TV documentaries and used in a trial with 12 schools in County Durham looking at the link between fish oils and children's concentration.

It combines omega-3 and omega-6 oils in a creamy fruit flavoured blend to appeal to children. Parents can get a free sachet of Eye Q smooth to make sure their children like it before buying by phoning 0870 241 5621.

Chemist Brokers
tel: 023 9222 2500

Pharmacy in the **community**

United Co-op Healthcare has a community ethic and encourages its pharmacists to voice their opinions. Jane Ellis reports

United Co-op Health Care operates nearly 130 pharmacies throughout the North West, North Midlands and North Wales, as well as the Sants and Wardles wholesale operations. There are 112 branch pharmacy managers with around 16 second and relief pharmacists. A few pharmacists, including professional development pharmacist James Murray, also work at the company's head office in Etruria, near Stoke-on-Trent.

Mr Murray qualified at Aston University, then worked for Boots The Chemists as a pre-reg student. He joined United Co-op in 2002 to run one if its busy branches in Greater Manchester. Last year he also took on the role of local pharmacy tutor for East Cheshire, which he continues to do, in addition to his head office role where he is working on the company's strategy regarding the new contract for pharmacy.

Group HR manager Rebecca Sumners says a typical United Co-op pharmacist is people-oriented, professional and honest. Pharmacists are also encouraged to get involved in new initiatives, come up with ideas and not be frightened of voicing their opinions. "As we're a small chain, we can be more agile and change what we want. We encourage staff to think about the job and the company and at our staff forum we like them to be vocal and have opinions," she says.

There are many opportunities for career development. A good example is the path taken by John Nuttall, general manager, who after qualifying joined the company in 1987 as the manager of a pharmacy in Tunstall in the Potteries. He quickly rose through the ranks to become superintendent pharmacist and general manager, at the age of 39, three years ago. Mr Nuttall now heads a business whose turnover increased by 9 per cent to £132 million to January 2005. He has led the vertical integration of the group. Further expansion is in the pipeline, with Yorkshire as a key target area.

James Murray (left) and John Nuttall

United Co-op also caters for staff pharmacists with children. "We have a family friendly policy and there aren't many exceptional opening hours. Our pharmacists generally work from nine to six. Nevertheless, we are aware that we need to be flexible and contracts that coincide with school terms are being investigated," says Ms Sumners.

The company offers a mixture of professional and interpersonal training and has structured appraisals. Pharmacists attend four to five training days a year. It also runs CPD workshops and modular computer-based training, together with courses on basic PC skills and health and safety.

United Co-op pharmacies are also very much part of the community and put investment back into their locality, for example through donations to charitable foundations, supporting scout groups and local events.

This community ethic also runs through the company. Staff are offered a number of benefits from childcare vouchers to cheap cars, free share options and, unusually these days, a final salary pension.

Further financial incentives are offered through a bonus scheme.

For more information: www.coop.co.uk

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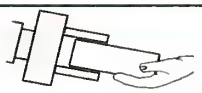

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Sunny Sintra

Golf, snakes, landmines: Patrick Grice saw the lighter side of the AAH convention

For most Britons, Portugal means port wine, the Algarve, that football team (yes, the one that lost to Moscow...), and some hazy recall of it being a place where us Brits duffed up the French a few years back – something to do with Richard Sharpe, or was it Wellingtons...?

The Portugese quite sensibly focus on different bits of their national heritage. Anyone on the AAH convention in Sintra last week who couldn't work out what, where or who Vasco de Gama might be, must be blind and/or deaf.

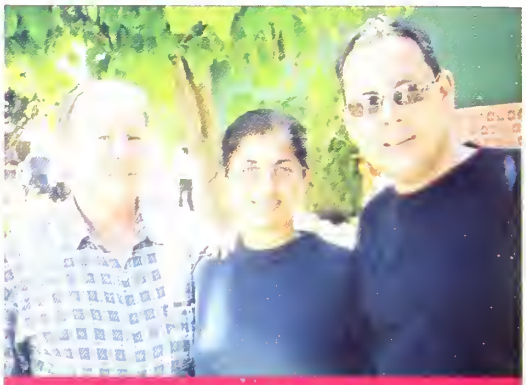
The convention (*C&D, 28May, p30 and this issue p34*) provided its usual mix of learning and levity. Where else but a wholesaler convention can you learn all about N3, ETP and NICE in the morning, and how to react if you leg is blown off by a landmine, or you are kidnapped by terrorists, in the afternoon, and find a 10ft python gliding under your dining table in the evening? It all helped put the skill mix debate into perspective.

Of course there was golf – in fact if you were not prepared to leave the surroundings of the hotel there was little else since the building was enveloped by two rather fine courses.

The usual suspects trundled up and down the fairways – rather more up and down than many were used to – and someone won the inevitable competition.

For those in search of salacious tales to recount to a wider audience, it must be recorded that the 2005 AAH convention ran like clockwork, and even those rowdy lads from the generics sector were (relatively) well behaved.

But let's not forget that perennial talking point for Brits abroad – the weather. The local guides were keen to point out that Sintra has its own micro-climate, which meant that while the surrounding countryside basked in sunshine, clouds often hid the peaks in which the town nestles. And it did seem rather windy....



The gentleman from Aspar Pharmaceuticals (above) Terry Prudhoe (left) and Tim Stanton (right) with Nottingham LPC chairman Makinder Suri. Terry was spotted in the casino in Estoril after the gala dinner in Lisbon. Doesn't the man need sleep? The gala dinner (below) at the Beato Convent in downtown Lisbon took the voyages of discovery of Vasco de Gama as its theme. There wasn't a nun in sight

No, it wasn't Mandeep Mudhar's 30th birthday (below), it was the Vantage symbol group's anniversary. The cake looked good, but did anyone get a slice?

'Barnacle Bill' Maginnis (below) samples local seafood. The barnacles, which resemble lizard toenails, tasted delicious, she insisted. Other diners at a soirée hosted by GSK Consumer Healthcare were not convinced, but Ms Maginnis (who has a cast iron stomach) sucked and chewed her way through the entire serving to win a bottle of Champagne

Roche Diagnostics' David Johnson (above) was determined to get his money's worth out of sponsoring the 'activity day' at the Lezira Riding Centre. The stallion was trained for the bull-ring and, everyone agreed, was a splendid beast...

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